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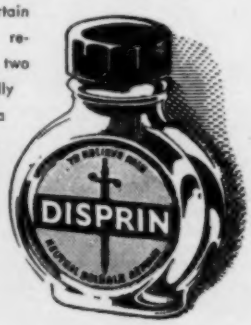

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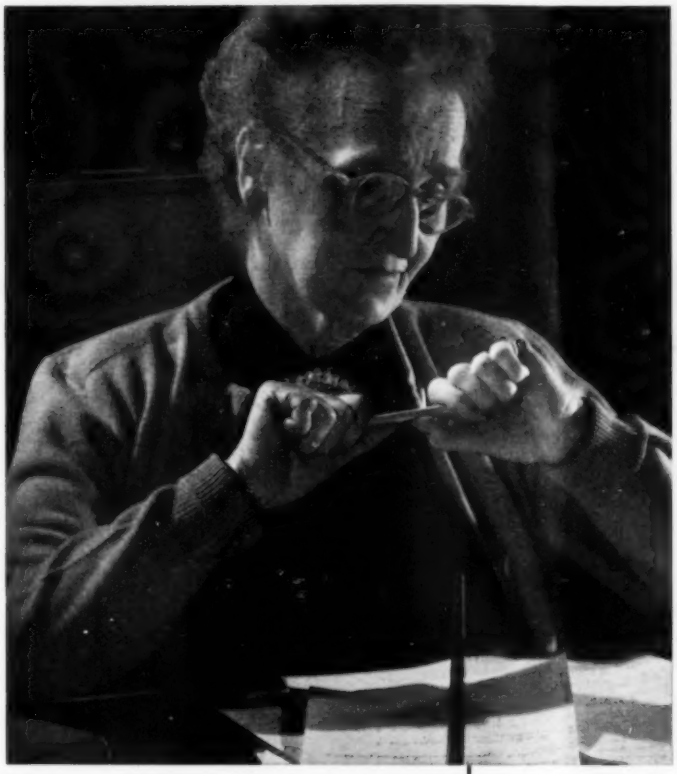

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1. Council on Pharmacy & Chemistry: New and Nonofficial Remedies 1953, Philadelphia, J. B. Lippincott Co., 1953, p. 252.

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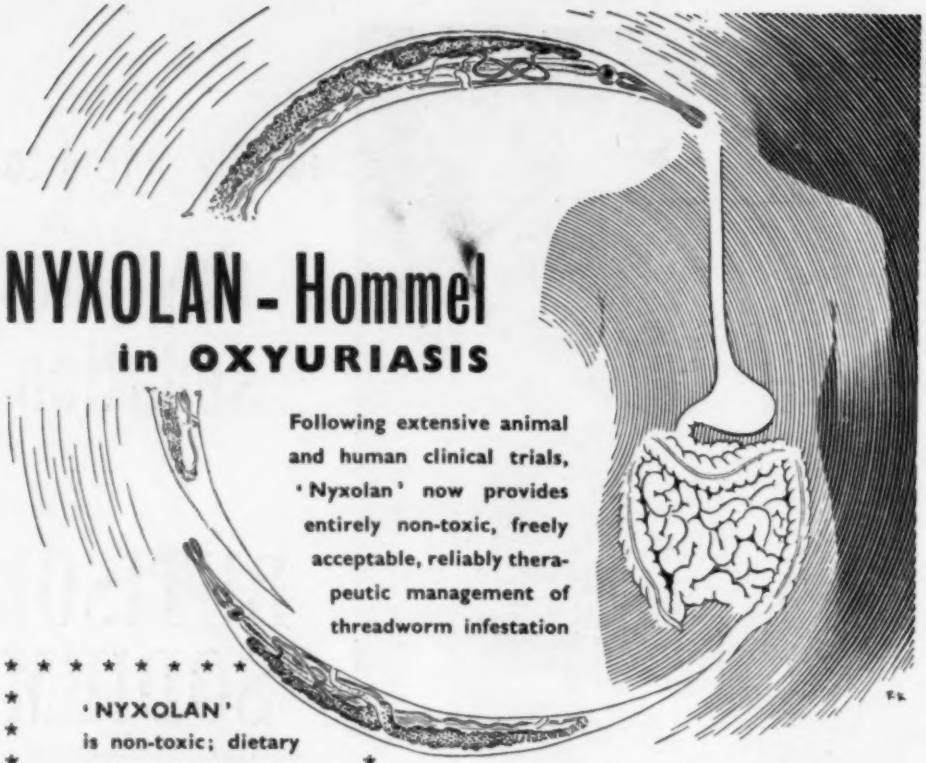

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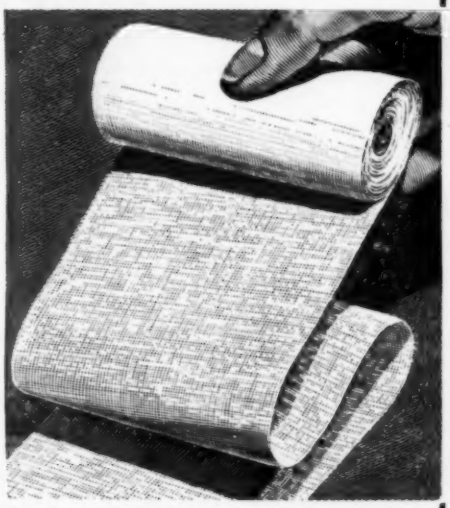

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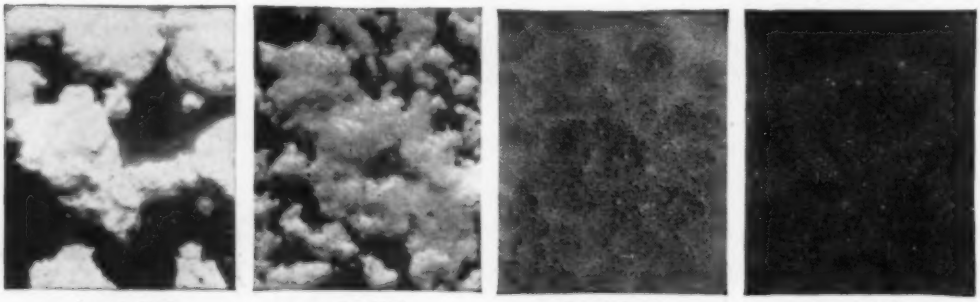

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PSYCHIATRY IN A GENERAL HOSPITAL

G. A. ELLIOTT, M.D., F.R.C.P.

Professor of Medicine, University of the Witwatersrand

During the period 13 July to 23 December 1953 I visited medical schools, hospitals and other institutions in Western Europe, Great Britain and the United States as a Travelling Fellow of the World Health Organisation. The main objective was to study the integration of psychiatry and internal medicine in the medical curriculum, the psychiatric care of general hospital patients, and certain aspects of postgraduate education in psychiatry. I visited some 30 medical schools, and a similar number of psychiatric institutions, research institutes and general hospitals in Switzerland, Holland, Denmark, Sweden, Norway, England, Scotland and the United States. In the course of enquiries I interviewed over 150 psychiatrists, physicians, neurologists, and others concerned with these subjects.

Apart from other visits to institutions, I was admitted to many types of psychotherapeutic sessions, took part in educational exercises with undergraduate and postgraduate students in medicine and in psychiatry, was privileged to address numbers of groups, and attempted to achieve the objectives of the tour by studying the influence which the social, economic and cultural background of the communities visited has on the health of a nation in general, and on the nature of psychotherapy applicable in different countries in particular.

Out of the mass of information and observations recorded each day of the tour it was possible to observe that certain trends and practices appeared consistently in every country, others were specific to one particular country, and yet others specific to individuals.

In all the countries I visited I found that emphasis was placed on attention to the psychiatric needs of general-hospital patients, on attention to certain types of psychiatric patient in a general-hospital atmosphere, and on the teaching of psychiatry to undergraduate students in the wards and out-patient departments of general hospitals. This article deals with the subject of psychiatry in the general hospital from the points of view of the care of the patient and the teaching of psychiatry to medical students. It is not implied that the practice of psychiatry in a general hospital differs in any qualitative manner from the practice of psychiatry in a specialized mental hospital, or that the teaching of medical students in psychiatry in general hospitals should displace teaching in mental hospitals. On the contrary, as will be pointed out, both groups of patients must be embraced in teaching, and the artificial gulf between the two types of hospital—the general hospital and the mental hospital—must be narrowed and bridged by the intermingling of staff and a broadening of concept of the types of patient admitted to each type of hospital, so that the mental-hospital psychiatrist in particular has freer access to the psychiatric and other clinical practice of a general hospital.

It is universally accepted that a general hospital requires:

(*a*) Adequate psychiatric staffing for the needs of general-hospital in-patients and out-patients, including those in the special psychiatric in-patient unit and psychiatric out-patient department that every general hospital ought to have. The staff must include psychiatrists, psychologist and psychiatric social workers, and, for the in-patient unit, mentally-trained nursing staff.

(*b*) A psychiatric in-patient unit for certain types of psychiatric case which inevitably form part of any general-hospital patient population, and in the interests of which co-operation between psychiatrists and physicians, and access to the diagnostic and therapeutic facilities of a general hospital, are essential.

TYPES OF GENERAL-HOSPITAL IN-PATIENT NEEDING PSYCHIATRIC ATTENTION

The types of patient in a general hospital that need psychiatric attention may be classified as follows:

(*a*) Acutely disturbed patients, as in delirium tremens with pneumonia or other physical illness, congestive

cardiac failure with cerebral ischaemia, meningitis, brain injury and other forms of organic reaction state. Such patients are admitted in the first instance to a general hospital because of their physical condition. Their disturbed mental state is acute and temporary, and it can be anticipated that on improvement in their physical condition they will become quiet and manageable and once more suitable for attention in a general ward. During their acutely disturbed phase, which may last a few days or longer, these patients require specialized nursing attention such as can best be given by nurses with mental nursing qualifications. They are a source of serious disturbance to the other patients in a general ward, and may be responsible for the precipitation of relapses in cardiac cases, cases of status asthmaticus and other physical conditions susceptible to psychological trauma who happen to be in the same ward. They are unfit to be moved to another institution in the acute phase of their illness. They need the skilled co-operative attention of physician and psychiatrist, and the investigative facilities of a general hospital. It is not desirable to certify them.

(*b*) Acutely disturbed cases admitted for investigation of a possible physical cause of symptoms, who are found to be suffering from psychiatric disturbances with little, if any, physical background, and of a longer lasting type than was at first suspected. Such cases include in particular, noisy hysterics, psychopaths, and occasional psychotics. They are unsuitable for a general ward of a general hospital, may have to be certified after a period of observation, and pending decision regarding disposal should be accommodated in a special psychiatric unit of the general hospital (to which they were admitted), served by a mentally trained nursing staff. Experience in the Transvaal has shown that such patients may have to be retained in the general hospital for days or even weeks before accommodation can be found in a suitable psychiatric institution. There is no hard and fast line of distinction between this type of case and the type referred to in the preceding paragraph, particularly during the first days in hospital.

(*c*) A few, but by no means all, of the patients suffering from the so-called 'psychosomatic' conditions (status asthmaticus, ulcerative colitis, certain skin conditions etc.), who need expert physical and psychiatric attention and the facilities of a general hospital, who are unfit for treatment as out-patients, and who are not suitable for nursing in a general ward but need special psychiatric nursing attention and freedom from the irritations and anxieties experienced in a general ward (the sight of dying patients and worried and mourning relatives, etc.). This group is not certifiable.

(*d*) Cases apparently psychoneurotic, admitted for investigation of their physical state, and subsequently shown to have no organic disorder, but who need continued in-patient treatment. Such cases are not certifiable, and may require to be transferred to a special psychiatric institution, or, particularly if there is any doubt about their freedom from organic disease, to be accommodated in the psychiatric unit of the general hospital.

(*e*) Cases with readily recognizable organic disease which is causing disablement, such as mitral stenosis or peptic ulcer, but with a significant and important psychiatric symptomatology superadded. These cases may need intensive observation and investigation by psychiatrist and physician before a decision can be made regarding some form of physical treatment, such as valvotomy for mitral stenosis or gastrectomy for peptic ulcer. During the period of observation they need in-patient attention. A limited few of these cases may be more suitably attended to in the psychiatric unit of a general hospital rather than the general medical wards. They are not certifiable.

(*f*) Attempted suicides. After recovery from the physical effects of their attempt these cases need psychiatric attention. Some are suitable for management as out-patients, some have to be transferred to a psychiatric institution, whether as certified or as non-certified cases, but a few who require continued physical and psychiatric attention, are better accommodated in a psychiatric unit of the general hospital.

A special unit for cases of barbiturate poisoning, in which both the physical treatment and the necessary psychiatric treatment during the immediate recovery phase can be given, situated in the psychiatric unit of the general hospital, is worthy of consideration. Dr. Carl Clemmensen's unit of this type in Copenhagen has been strikingly successful, at least as regards recovery from the acute phase of poisoning.

(*g*) Cases of acute alcoholism, uncomplicated by physical disease or injury. These are not suitable for admission to the psychiatric in-patient unit of a general hospital. 'Recovery' rooms for these cases should be provided in the casualty department.

TYPES OF PSYCHIATRIC IN-PATIENT UNIT IN A GENERAL HOSPITAL

The psychiatric in-patient unit of a general hospital may be of several types:

(*a*) A small unit sufficient to cater for the types of case enumerated above which occur in the wards of the general hospital. Only exceptionally would cases be admitted to this unit from the psychiatric out-patient department of the general hospital, particularly if there were accommodation elsewhere. For a hospital of about 800 beds there should be single and double-bedded wards for 6–8 cases of temporary disturbance, and larger wards to accommodate about 20 of the quiet cases described. These latter beds, if not all occupied, can be used for suitable general medical cases.

Patients seriously ill from physical disorders, particularly if they are likely to die, should not be admitted to the public wards of this unit.

Dr. Stanley Cobb's unit at the Massachusetts General Hospital is a good example. It is simply equipped, and consists of 4 rooms for acutely disturbed cases from the wards of the hospital, and about 20 beds for psychoneurotics and quiet observational cases. It includes a day room, and provision for table tennis and simple occupational therapy, but no outdoor recreational facilities. Dr. Cobb has the good-will of his colleagues, and is insistent that the success of the unit is due to its location in the hospital building—'across the road

would be too far away'—and the enthusiasm and effectiveness of the staff of the unit. In the disposal of its patients, the unit works in co-operation with the psychiatric out-patients' department.

In the Aberdeen Infirmary Professor W. M. Millar, Professor of Mental Health at the Aberdeen Medical School, has a newly-established unit which consists of 12 beds, in charge of a sister trained in mental nursing. There is as yet no accommodation for acutely disturbed cases from the Infirmary, only quiet cases being admitted.

The York Clinic under the care of Dr. Munro, senior psychiatrist at Guy's Hospital, London, is another small psychiatric in-patient unit in a general hospital.

St. George's Hospital, London, has a 30-bed neurosis unit at Wimbledon, about 30 minutes away from the hospital itself, under the care of Dr. Desmond Curran. The medical school and the students find the distance inconvenient. (Provided this small type of unit is properly staffed (see below), the equipment and furnishing should be of the simplest. Facilities must be provided for occupational therapy, psychotherapy, and a limited amount of electro-convulsant therapy. Insulin-coma facilities are not as a rule provided. Not much day-room accommodation is needed, since most of the patients will be bed patients. Simplicity should be the key-note, in order to facilitate the transition to home and out-patient care.

If there is a day treatment centre associated with the psychiatric out-patient department of the hospital, this in-patient unit carries out the electro-convulsant therapy, holding the patient for an hour or two after each treatment before sending him home.

(*b*) A large unit of 80–150 beds to serve the same purposes as the small unit but, in addition, to admit psychoneurotics and observational cases that are not certifiable (at least at the time of their admission) from the psychiatric out-patient department of the general hospital in which the unit is situated. Such units are common in Holland, Scandinavia and the United States, in which countries it is normal policy to build general hospitals to include such units. Examples of such units within the precincts of general teaching hospitals are those of Professor L. van der Horst at the Wilhelmina Gasthuis, Amsterdam; of Professor H. Rümke at the Akademiese Ziekenhuis, Utrecht; of Dr. Carl Clemmenson at the Bispjeborg, Copenhagen; of Dr. Wulfahr at the immense Södersjukhuset in Stockholm; and of Professor Sjögren at the Karolinska Institute, Stockholm; the Phipps Clinic in charge of Dr. J. C. Whitehorn at Johns Hopkins Hospital, Baltimore; the Payne-Whitney Clinic under Dr. O. Diethelm at New Cornell, New York; Dr. John Romano's Wing 'R' at Rochester School of Medicine, N.Y.; and the newly-established 100-bed unit at the Southern General Hospital, Glasgow, under Professor T. Ferguson-Rodger.

Facilities for therapy are usually wider in scope than in the smaller units, and include provision for insulin coma. As in the smaller units, day-treatment patients needing electro-convulsant therapy are given it in this in-patient unit, where they stay to recover for an hour or two.

(*c*) The 'observation ward', common in Great Britain. A ward of this type may accommodate up to 150 patients. The patients admitted include acutely disturbed cases with or without physical disease, acute psychotics for observation and disposal, attempted suicides, and patients who for any reason have become unmanageable or a danger to themselves and others at home or in general wards. Many are admitted on temporary certification. The function of this ward is to treat the acute physical and psychiatric state, and to recommend disposal within about 2 weeks of admission or less. Disposal may be by discharge, transfer to the general wards of a general hospital after the acutely disturbed phase has passed, or transfer to a psychiatric institution for certified or non-certified cases. Units of this type, modernized and adequately staffed by psychiatrists assisted by physicians, provide a first-class service to patients and an admirable teaching service. A good example is the observation ward at St. Francis General Hospital, 10 minutes from the Maudsley Hospital, London, and staffed by the Maudsley psychiatric staff, including full-time registrars in training. It is used only for post-graduate instruction. The observation ward at the Newcastle General Hospital, in a rather ramshackle old building which is more than offset by the excellent psychiatric-medical and nursing staff under the direction of Dr. Alexander Kennedy, Professor of Psychologic Medicine, affords a first-class service to patients and a teaching service to students.

Since admissions to such wards include patients certified under the Mental Disorders Act, their establishment in general hospitals in South Africa would be dependent on agreement between the Union Government and Provincial Administration.

The observation ward provides an important social service. It permits of the expeditious disposal of acutely disturbed cases in the home, where they are a notable cause of disruption. The attending medical practitioner, private or hospital, is saved many hours in disposing of a psychiatric emergency.

(*d*) Research Units, such as that under the direction of Dr. J. Groen in the Wilhelmina Gasthuis, Amsterdam. The objective of this unit happens to be research in 'psychosomatic' disorders, but other objectives pertain to other units. Certified patients are not admitted. The special feature of these research units is the heavy staffing. The staff of the Amsterdam unit includes 2 full-time physicians, 2 psychiatrists, a psychologist, a sociologist, a biochemist, a physiologist, and secretarial assistants.

In the Cincinnati General Hospital, under Dr. Maurice Levine, is a 12-bed psychosomatic research unit, very adequately staffed by psychiatrists, psychologists and physicians. The emphasis is on research, and teaching in the unit is confined to post-graduate instruction. All medical residents (registrars) of the hospital spend a period of about 3 months with the unit during their 3 years' residence.

(*e*) A State psychiatric institution associated with the general hospital. This is exemplified in the State Institute of Psychiatry of New York, which is situated in the vicinity of the Columbia Medical School at the Presbyterian Medical Centre. The Director of the Institute

is also Professor of Psychiatry in the Columbia Medical School, the appointment being made co-operatively between the State and the Medical School. The patients include psycho-neurotics, certified and uncertified psychotics, and 'voluntary boarders'. Research is a prime function of the Institute, and considerable emphasis is placed on admitting types of case from the whole of New York State that suit the numerous research projects of the Institute. Annual courses of instruction are held for medical officers of the State service. The main difference between this type of psychiatric unit in a general hospital and the type described under the preceding paragraphs is the administrative co-operation that is necessary between the State, the medical school, and the general hospital authorities.

The establishment of an Institute of this kind in South Africa would require co-operation between State, Province and University. Its value to the community would be tremendous, making possible, as it would, research into mental disorder of all types.

(*f*) A staff of psychiatrists, psychologists, and psychiatric social workers who work on a co-operative basis with physicians, surgeons, obstetricians and gynaecologists on the staff of the general hospital, attending to the psychiatric needs of the patients in the wards and out-patients department, but without any specific psychiatric in-patient or out-patient department. The outstanding service of this type visited was that of Dr. Henry M. Fox, Associate Professor of Psychiatry of Harvard Medical School, at the Peter Bent Brigham Hospital. Dr. Fox, with a generous staff of psychiatrists, psychologists and psychiatric social workers, studies and teaches on patients in the general wards, medical, surgical and gynaecological, of the hospital, and in the out-patient departments.

A full-time psychiatrist attached to a general hospital with no provision for a psychiatric in-patient or out-patient unit, and no research facilities, would not appear to constitute a satisfactory psychiatric service for the hospital. Two such services were seen, one in Scandinavia and one in the United States. In both instances, the incumbent of the post felt isolated, having no department of his own and being attached to no department of the hospital. There was a tendency to be inundated with patients referred by the hospital staff 'for disposal'. There was no time for research, and teaching only on isolated consultation cases was unstimulating to both the teacher and student, and was basically unsound. From the patient's point of view, the system is unsatisfactory in that there is no choice of consultant. A psychiatric service to a general hospital will not be satisfactory either for patients or students, unless it is provided with beds for psychiatric patients and a psychiatric out-patient department, or with very adequate facilities for research.

STAFFING OF A GENERAL-HOSPITAL PSYCHIATRIC UNIT

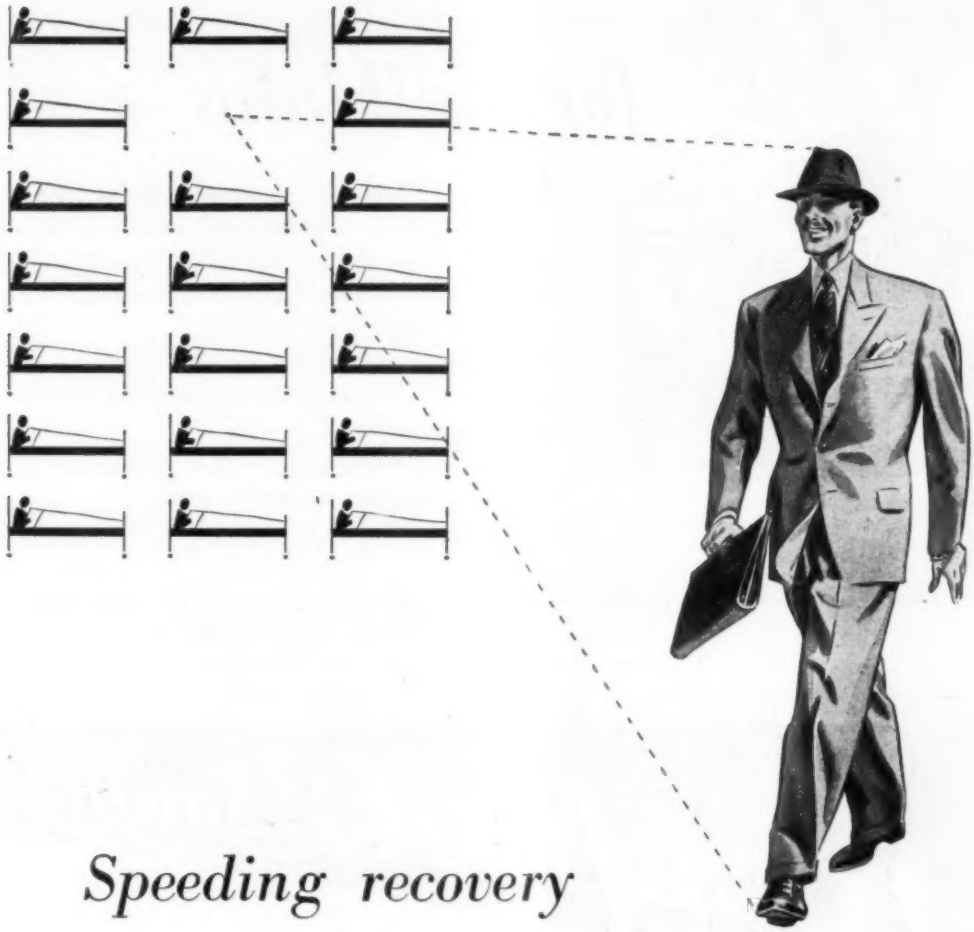
The staff of the in-patient psychiatric unit of a general hospital must include psychiatrists, psychologists, and psychiatric social workers, as well as physicians. The clinical psychologist undertakes psychometry and assists in therapy. The nursing staff must include sufficient nurses with qualifications in mental nursing to provide a continuous 24-hour service. In a 20–30 bed unit, 3 is the minimum number, each working in 8-hour shifts. The new category in South Africa of 'Psychiatric Nurse' would be admirably suitable. The remainder of the nursing staff need not necessarily be mentally trained. The psychiatric staff of this unit should include the staff serving the psychiatric needs of the in-patients of the hospital generally and the psychiatric out-patient department, in order to provide continuity of service to patients passing from one section of the hospital to another.

The size of the psychiatric staff will depend on the financial considerations. Supplementation of the paid staff, part-time or full-time, by honorary staff, should be considered. At the Phipps Clinic at Johns Hopkins and the Payne-Whitney Clinic at Cornell, the majority of the staff above the rank of resident (registrar) are unpaid and honorary.

The sources from which the psychiatric staff are drawn will vary according to local conditions. In South Africa the hospital care of mental health is divided between the Provinces and the State; in general teaching hospitals the University is also concerned. The psychiatric staff of a general hospital should, in my opinion, include psychiatrists in private practice locally (who fall into the category of Provincial part-time staff, or, at teaching hospitals, joint Provincial-University staff), psychiatrists from the State mental-hospital service, and psychiatrists holding full-time Provincial or joint Provincial-University appointments. In a teaching hospital the Professor of Psychiatry may hold a joint Provincial-University appointment, or a joint Provincial-University-State appointment. The success of this triple-origin staff is manifest at the Columbia Medical School, New York, and at Aberdeen, Scotland.

In Aberdeen the triple-origin staff serves the psychiatric out-patient department. The 3 institutions interested in mental health, namely, the University through the staff of the Department of Mental Health (who also provide a service to the in-patient psychiatric unit of the Aberdeen Infirmary), the State Mental Hospital service through the staff of the nearby Kingseat State Mental Hospital, and the regional National Health Service psychiatric staff, meet as a unified staff in the psychiatric out-patient department. This amicable arrangement has been outstandingly successful in stimulating co-operation and unifying the interests of the different institutions serving mental health.

The psychiatric patient and teaching service of the University of Oslo is another example of a successful tri-partite staffing and administrative arrangement for the care of the mentally sick. The general teaching hospital is the Rikshospital, which is a municipal hospital. About 5 minutes away by public transport is the University Clinic under the direction of Professor Gabriel Langfeldt, who is paid and appointed by the University. This clinic accommodates as in-patients about 100 non-certifiable psycho-neurotics and cases for psychiatric observation and diagnosis; it admits cases from its own out-patient department and from the Rikshospital. Professor Langfeldt is known as the



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Professor of Minor Psychiatry, and in addition to his University salary receives an honorarium from the Municipality. About 15 minutes from the Rikshospital is the Gaustad State Mental Hospital, of which the director of the male section is appointed permanently to this post on account of the University association, and cannot be moved to another State Mental Hospital. The appointment is made by the State and the University It is held by Professor O. Odegaard, who is known as the Professor of Major Psychiatry. The system works amicably, and apparently efficiently, in regard to both patients and teaching.

The same principles of staffing apply to the psychiatric *out-patient* unit of a general hospital, with the exception that nursing staff qualified in mental nursing are not necessary. It is in the out-patient department particularly that the staff contribution fom the State mental-health service is likely to be most effective.

FUNCTIONS OF THE PSYCHIATRIC STAFF IN A GENERAL TEACHING HOSPITAL

There is no country that does not recognize that the teaching hospitals set the standards of hospital practice for the country. They stimulate advancement of knowledge and a high standard of practice.

A well-administered, competent and sympathetic psychiatric service in a teaching general hospital brings considerable advantage to the patient. (This aspect will be dealt with in a later article).

In a teaching general hospital the way in which the physician, the psychiatrist, the student and the patient are brought together to the advantage of each, will vary with local conditions. The psychiatrist, for his part in addition to providing a routine service for patients, must take an active part in the teaching of medical students in the general wards and possibly the general out-patient department, and in the psychiatric in-patient and out-patient sections.

It is elementary principle of all clinical teaching that the teacher must bear responsibility to the patients whom he teaches, and must have intimate knowledge of both their physical and mental condition. If he is to take part in the teaching in the general wards, as he must, the psychiatrist on the staff of a general teaching hospital must be an integral part of the attending staff of the general wards, particularly of the medical wards. (His function in these wards is discussed more fully below.) His function both as regards routine service and teaching, in the psychiatric in-patient and out-patient sections of the general hospital is self-evident.

It is not my intention to discuss in detail in this article the principles and methods of teaching psychiatry to medical students. It is, however, necessary to consider the general approach to this teaching, in order to appreciate the part played by the psychiatric staff, of the general hospital, and the place of the general-hospital patient in the teaching scheme.

It is generally accepted that the teaching of psychiatry to medical students must, at some stage of their training, be on 'the psychiatry of everyday practice'. The patients falling into this category include those suffering from psychoneuroses, mild depressions and early psychoses, the milder psychopaths, and those with psychiatric emergencies such as the acute confusional states. Those patients are commonly found in the general out-patient departments and wards and the psychiatric out-patient and in-patient sections of a general hospital, rather than in specialized psychiatric institutions whether for certified or uncertified patients. Only the severer grades of the above-mentioned disorders are ordinarily admitted as in-patients to such institutions. In a general hospital the student should see the general wards as the meeting ground for the physician, surgeon, gynaecologist and psychiatrist. He is able to see patients suffering from physical disease and must be taught to appreciate that such patients always have some degree of psychiatric deviation, which may be more disabling than the physical disorder, and he must learn to distinguish psychiatric manifestations which are due to the physical disorder from those that are not. He sees the so-called psychosomatic disorders requiring the combined skilled attention of physician and psychiatrist, and the visceral neuroses with their headaches, dyspepsias, backaches and palpitations. He appreciates more readily that the patient is not to be compartmented, the body being treated in one hospital and the mind in another. He can study the psychiatric aspects of patients in the atmosphere of all branches of clinical practice. Even without formal and didactic teaching, the student in such an atmosphere learns gradually to regard the body and mind as one functioning unit, provided that he sees and appreciates sincere and natural co-operation between physician and psychiatrist. Both psychiatry and medicine gain by being practised alongside each other, and this mutual benefit reflects itself in improved patient-care.

In the psychiatric in-patient section of the general hospital, the student sees the management of psychiatric emergencies, the severer psychoneuroses that may be admitted, and selected 'psychosomatic' disorders, again in the atmosphere of co-operation between the physician and the psychiatrist. In the psychiatric out-patient department of the general hospital he sees patients whose clinical presentation is predominantly psychiatric, and is afforded the opportunity of seeing the same psychiatric staff as teach him in the comparative leisure of the wards, handling and disposing of larger numbers of cases with the practised skill of experience. spending less time on tuition in diagnosis, and more on disposal, an aspect of practice that is thought-provoking and complementary to the more deliberate approach in the wards.

In the wards, general and psychiatric, or in the psychiatric out-patient department, the student can be introduced to such forms of psychotherapy as may be practised by the psychiatric staff, provided the therapist does not object to the presence of persons other than patients and himself at the therapeutic session.

Even with the provision of ideal facilities for the psychiatric care of general-hospital patients and for the teaching of clinical psychiatry, the students must continue to receive instruction in clinical psychiatry in mental hospitals. In them they see the more severe psychiatric disorders; they see not only cases that are obviously unfit to live outside the institution, but also those that are at first sight normal but who actually may

be cases of dangerous paranoia. They see specialized forms of treatment such as insulin coma, electro-convulsant therapy, and psychosurgery about which they must have some knowledge for the sake of the principles of psychiatry which such procedures teach, and because they need a nodding practical acquaintance with these procedures when they later advise on disposal and prognosis in patients in their own practices. The right way to fill in clinical details on the forms required for certification under the Mental Disorders Act is best learned over the certified cases that have been admitted to an institution. Amongst these cases they will see those that were justifiably certified, and those that should not have been certified.

Medical Students' Course in Psychiatry. It is widely held as correct that the course should begin in the first clinical year of the curriculum, when it should deal with the more severe deviations from normal ('mental hospital cases') and take place to a large extent in institutions like our mental hospitals. Early introduction to this type of case familiarizes the student with the meaning and social significance of mental disorder, in that he sees the indubitable deviations from normal consciousness, perception, judgment or feeling, in the form of hallucinations, delusions, severe depressions, mania, loss of contact with reality, states of severe chronic confusion, and dementia. Introduction to clinical psychiatry of this type furthermore minimizes the chances that the student, by identification with the symptoms of the less serious deviations such as the psychoneuroses, will develop disabling psychoneurosis himself.

Having been introduced to the severe psychiatric deviations in the first clinical year, during which time he is also being introduced to clinical medicine and surgery, the student proceeds to 'psychiatry of every-day practice' in the second and third clinical years of study particularly in the general hospital. At this stage he can be introduced to dynamic clinical psychiatry, including child psychiatry, having already completed a course of instruction in normal psychology and development based upon dynamic concepts, not necessarily purely Freudian in nature. Clinical instruction in the less severe psychiatric disorders demands a better knowledge of clinical medicine than the students have in their first clinical year.

This general approach to the teaching of clinical psychiatry is similar to the approach to the teaching of all clinical subjects. First, the student must be taught the normal. Then he must learn to recognize the obviously abnormal. Thereafter, he must gradually learn the most difficult aspect of clinical practice, namely, the recognition of the lesser deviations from normal.

The methods adopted in teaching psychiatry in the general hospital will vary according to the size of psychiatric staff, the accommodation available, especially in the out-patient department, and the numbers of students.

In this article, main consideration will be given to the teaching of psychiatry in the general wards of the general hospital, particularly the medical wards, but the teaching can be extended to include any wards, such as the skin surgery and gynaecology wards. There are many different methods adopted in different countries, the common objective being to bring together the psychiatrist, physician, student and patient.

A method in general favour is for the staff of the general ward to include one or more psychiatrists, who provide a service to the patients as well as a teaching service to the students. These two functions have much common ground.

There should be teaching rounds with senior students (second and third clinical years), at which psychiatrist and physician attend jointly, and at which the physical and psychiatric state of each patient is discussed between physician, psychiatrist and student, the emphasis of the physician's and psychiatrist's interest naturally varying with each case. Neither physician nor psychiatrist should ever admit that a case is devoid of either physical or psychiatric interest. Every fracture, every obstetrical delivery, every cardiac, has psychiatric interest. A ward round of this joint type once a week in each ward is valuable to the physician, the psychiatrist and the student. The physician and the psychiatrist see each other's point of view, and the student, provided the round is conducted properly, sees medicine and psychiatry discussed on an equal intellectual basis. The patient benefits from the joint opinions finally formed. In my experience students express great appreciation of the value of this type of round.

But ward rounds are not enough. The psychiatrist should hold at least one teaching session a week for each group of senior students attending the ward practice (in South Africa a second (clinical) year group and a third-year group). At this session, the main emphasis must be on instruction in *psychiatric interview technique*, using patients in the general ward. Rarely is a medical case not suitable for such type of instruction. Every rheumatic heart, peptic ulcer, hypertension, or coronary thrombosis in the recovery phase, is suitable. The students must be made to 'work up' such cases under instruction, spending anything from a single interview to a dozen with the patient before presenting the results to the instructing psychiatrist.

In all clinical practice, but particularly in the practice of psychiatry, instruction in interview technique is generally agreed to be an essential basis of learning. However much teacher-psychiatrists differ in their views on the extent or depth of dynamic psychiatry that should be taught to students, or whether or not to teach psychotherapy, all agree on the importance of teaching psychiatric interview technique. Many experienced teachers make it their chief aim in teaching. The interview elicits evidence on which to base a diagnosis; it provides a form of mental catharsis and is therefore in itself psychotherapeutic; it inspires confidence due to the time and interest devoted to the patient, and consequently is psychotherapeutic; it inevitably offers opportunity for explanation of symptoms to the patient, from which stems understanding and insight, and, again, the interview is consequently psychotherapeutic. At one and the same time, the interview serves both a diagnostic and a therapeutic function. In more than one notable general-hospital psychiatric service visited, experienced psychiatric teachers of international reputation demanded of their senior students no more than the eliciting of

evidence by interview; the interpretation of the evidence was left to the staff to discuss in the presence of the student who had elicited the evidence. The teaching of psychiatric interview technique must constitute the main mechanism in the teaching of clinical psychiatry to undergraduate students.

Many different opinions were met concerning the desirability or practicability of teaching psychotherapy as such to students. At the one extreme are those who advocate that students should be taught psychotherapy and carry it out on selected patients; at the other extreme are those who hold that its teaching should not be attempted. The advocates in favour of teaching in psychotherapy all agree that a 1:2 staff-student ratio is necessary. With this ratio, the student is able to discuss with his tutor for ½ hour his line of approach to the patient, whom he will be treating for the next hour. After the therapeutic session, at which he interviews the patient alone, he discusses for another ½ hour the procedure to be followed, and is advised regarding the procedure to follow at the next psychotherapeutic session.

Dr. Fox's system at the Peter Bent Brigham Hospital is described above. If it is to be successful, this system will be expensive in both accommodation and staff.

The psychiatric staff of the general ward supply a diagnostic and a psychotherapeutic service to the patients in the ward and later in a follow-up clinic. They normally would not control beds in the general ward; but they would be in charge of patients in the psychiatric in-patient unit.

The teaching of psychiatry to medical students in the psychiatric out-patient department of the general hospital, the importance of which cannot be over-emphasized, follows orthodox pattern. It includes the teaching of interview-technique and the rapid assessment of disposal. The detail of teaching arrangements will vary with the size of staff and the amount of accommodation, and the organization of the teaching will necessitate the allotment of fewer cases to those psychiatrists engaged in teaching, and an efficient system of student rosters. Both from a service point of view and from the point of view of teaching, adequate accommodation *must* be provided.

Teaching in the psychiatric in-patient unit of a general hospital must be planned according to the size of the unit and its staff, and the number of students. The students must see the co-operation between the psychiatrist and the physician.

The teaching of psychiatry by psychiatrists in the medical out-patient department is favoured in some schools. This requires a larger staff and more accommodation than out-patient teaching practice conducted by physicians alone.

THE INTRODUCTION OF NEUROSIS UNITS INTO STATE MENTAL HOSPITALS

The introduction of neurosis units to State mental hospitals is relevant to the trend, to which attention has aleady been drawn, to increase the scope of the work of the Medical Officer of the State mental hospital service and to integrate all the institutions concerned with the care of mental health.

At Graylingwall State Mental Hospital, Sussex, England, which is under the direction of Dr. Joshua Carse, a 'neurosis unit' of 80 beds has recently been established. The unit is accommodated in a new, simply-constructed building in the grounds of the hospital, with its own occupational therapy facilities. Patients are admitted to the unit with no more formality than if they were being admitted to a general hospital. The majority are psychoneurotics, but there are a number of quiet diagnostic problems that may later be found to be psychotic cases. The patients are recommended for admission from the psychiatric out-patient clinics in the general hospitals of 3 neighbouring towns, these clinics being staffed by the psychiatrists of Graylingwall Hospital. These clinics, in turn, have patients referred to them by the general hospital, by welfare clinics, and by the practitioners of the towns. A few patients are admitted from the 70-bed 'reception' section of Graylingwall Hospital, which receives 'voluntary boarders', who, if they improve sufficiently graduate to the neurosis unit for the completion of hospital treatment before being sent home.

The psychiatrist staff of the Graylingwall Mental Hospital therefore also supplies a service to the psychiatric out-patient department of 3 general hospitals, and a neurosis in-patient unit,.

At St. Hans State Mental Hospital, Roskilde, Denmark, there is a similar type of neurosis unit of 48 beds, simply and tastefully built and furnished, under the direction of Dr. G. Magnussen, which provides a pattern that the patient of modest means can follow when he returns to his simple home.

The practice of these two hospitals has gone a long way to removing the stigma still associated with the mental hospital. The acceptance of responsibility for the care of psychoneurotics, most of whom improve and return to their homes, in the eyes of the public puts the hospital into the same class as general hospitals.

Units of this sort in State mental hospitals, and the introduction of medical officers of State mental hospitals to the psychiatric units of general hospitals, help to bridge the gap between general hospitals and mental hospitals, and between physical sickness and mental sickness.

CONCLUSION

The integration of psychiatry with all clinical practice, and integration within itself, are desirable objectives that can be effected only by the co-operation and goodwill of all persons and institutions concerned in mental health, including all medical practitioners, universities with medical faculties, general hospitals (particularly teaching hospitals) and State mental hospitals. A long-term mechanism of integration is to breed, by the education of medical students, a generation of medical practitioners who will, with a natural effectiveness and in a mood of ethical and emotional neutrality, practise an integrated medicine in which mind and body receive the attention that is their due.

In South Africa, the matter is one for thought and action by hospital administrations, both Provincial and State, and by universities concerned with the education of medical students. The present contribution discusses and emphasizes the place of the general hospital, and in particular the teaching general hospital, in the integration process.

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EDITORIAL

ASCITES

Ascites commonly occurs in diseases associated with congestion of the hepatic and portal venous systems. Until recent years most observations on the formation of the fluid have been descriptive, but there is nowadays much literature dealing with the possible causes of the condition and the factors influencing the formation of ascites.

One view that has been widely held is that the fluid results from increased filtration into the peritoneal cavity because of portal hypertension. The evidence obtained from direct recordings of portal pressures in man suggests that portal hypertension is not usually the main factor responsible for the ascites of Laennec's cirrhosis. The collateral venous communications that are developed, e.g. oesophageal varices, dilated abdominal veins, and haemorrhoids, are also not necessarily indicative of portal hypertension, and more likely may limit the degree of portal hypertension. There is much evidence against the correlation of elevated portal pressure and the presence of ascites.

The protein-level of ascitic fluid varies greatly. The protein is electrophoretically similar to that of plasma. It has been supposed that such protein might retain fluid in the peritoneal cavity, but it has been shown that the intraperitoneal injection of salt-free albumin raises the serum albumin and that the quantity of ascitic fluid may actually become decreased.

The increased intra-abdominal tension produced by an accumulation of ascitic fluid that renders the abdomen taut exerts only a minor influence on ascites production.

In recent years it has become increasingly apparent that, as with oedema in general, the retention of sodium and water is very important in ascites. Once the optimum conditions of liver cirrhosis or congestion are developed the sodium ion becomes important in the production of ascites. Patients with ascites excrete salt poorly. The mechanism by which salt and water are retained in ascites has still to be satisfactorily explained. Sodium excretion is governed primarily by the renal tubules but their function is regulated by stimuli whose exact origins are not fully known. Over-activity of the adrenal cortex may occur in ascites as in generalized oedema.[1]

VAN DIE REDAKSIE

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Buikwatersug kom algemeen in siektes voor wat met bloedstuwing van die lewer- en portaarstelsels gepaard gaan. Tot onlangs was waarnemings i.v.m. die vloeistof meesal beskrywend maar deesdae is daar aansienlike literatuur oor die moontlike oorsake van die toestand en die faktore wat die formasie van buikwatersug beïnvloed.

'n Mening wat alom byval gevind het is dat die vloeistof deur verhoogde infiltrasie in die buikholte veroorsaak word as gevolg van drukverhoging van die poortaar. Regstreekse lesings van poortaardruk in die mens suggereer dat drukverhoging in die poortaar gewoonlik nie die hooffaktor is wat buikwatersug in Laennex-sirrose veroorsaak nie. Die bykomstige aarverbindings wat ontwikkel, byvoorbeeld slukdermspatare, uitgesette buikare en aambeie is ook nie noodwendig 'n aanduiding van verhoogde poortaardruk nie. Dit is meer waarskynlik dat dit die graad van poortaardruk beperk. Daar is heelwat bewyse wat teen die korrelasie van verhoogde poortaardruk en buikwatersug getuig.

Die proteïne-inhoud van buikwatersugvloeistof wissel baie. Elektroforeties is die proteïne en plasma eenders. Dit was veronderstel dat dié proteïne vloeistof in die buikholte mag behou. Dit is egter bewys dat 'n buikinspuiting van soutvry-albumine die serum-albumine verhoog en dat die hoeveelheid buikwatersugvloeistof in werklikheid verminder. Die verhoogde binnebuikse spanning wat veroorsaak word deur 'n akkumulasie van buikwatersugvloeistof wat die buik laat span, oefen slegs 'n geringe invloed op die formasie van buikwatersug uit.

Dit het in die laaste jare steeds duideliker geword dat, soos in die geval van edeem in die algemeen, die terughou van natrium en water 'n baie belangrike rol in buikwatersug speel. As die optimum toestande van lewersirrose of stuwing eers ontwikkel het, word die natriumioon 'n belangrike faktor in die produksie van buikwatersug. Pasiënte wat aan buikwatersug ly se soutafskeiding is swak. 'n Bevredigende verklaring moet nog gevind word vir die terughou van sout en water met buikwatersug. Die afskeiding van natrium word hoofsaaklik deur die nierbuisies beheer maar hul funksie word deur stimuli gekontroleer waarvan die presiese oorsprong nie ten volle bekend is nie. Oormatige bedrywigheid van die bynierskors mag aanwesig wees in buikwatersug asook in algeme watersug.[1] Dit is moontlik dat deoxycortone of verwante hormone die elektroliet-

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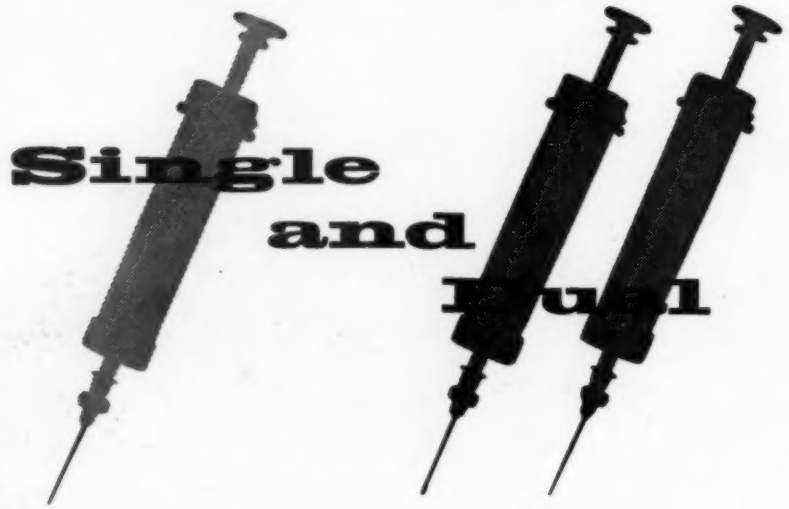

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It is possible that deoxycortone or allied hormones may produce the electrolyte changes observed in cirrhotic patients.[2] The antidiuretic hormone may be responsible for the salt and water retention of ascites;[3] an increased amount of this hormone may be found in the urine of patients with cirrhosis and ascites, but its presence has not been consistently demonstrated, and the role of antidiuretic factor is therefore still not certain. It has also been suggested that in the presence of liver damage certain sex hormones with salt-retaining properties may fail to be inactivated by the liver, as has been postulated for adrenocortical steroids and antidiuretic factor.[4] Other biologically active substances with antidiuretic properties have recently been demonstrated in patients with ascites and cardiac failure.

The mechanism of ascites has been the subject of much research in the last few years, and although important facts have been established the problem has still to be clarified.

veranderings kan veroorsaak wat in sirrotiese pasiënte waargeneem word.[2] Die antidiuretiese hormoon mag vir die terughou van sout en water in buikwatersug verantwoordelik wees;[3] daar is somtyds 'n toename in die hoeveelheid van hierdie hormoon in die urine van pasiënte wat aan sirrose en buikwatersug ly, maar die hormoon is nie altyd aanwesig nie en die rol van antidiuretiese faktor is herhalwe nog nie duidelik nie. Die mening is ook uitgespreek dat wanneer die lewer beskadig is, kan sekere geslagshormone met sout-terughoudende eienskappe nie deur die lewer buite werking gestel word nie, soos vir die bynierskorssteroïede en antidiuretiese faktor aanspraak gemaak word.[4] Ander biologies-aktiewe stowwe met antidiuretiese eienskappe is onlangs in pasiënte met buikwatersug en hartverlamming waargeneem. Baie navorsing is in die afgelope paar jare oor die buikwatersugmeganisme gedoen en alhoewel belangrike feite gekonstateer is, is die probleem nog nie opgelos nie.

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OESTROGENS IN FACE CREAMS

Millions of pounds are spent annually upon cosmetics. In some countries their manufacture is an important industry, and in the United States the part they play in medical practice is sufficiently large to warrant a study Committee on Cosmetics within the American Medical Association.

Cosmetic preparations probably exert their desired effects in 2 ways, for undoubtedly there is a psychological action attached to their use, an element of 'moral support' for the woman who feels that her face requires it. Secondly, cosmetics are said to exert a functional action on the skin itself, and the commercial houses have gone to fantastic lengths and expense to acquaint the world of their conviction that this is indeed so.

It has been known for a long time that oestrogens, either by injection or by local application to the skin, exert a slight hyperplastic effect on the epidermal cells.[1] This well-proven fact has aparently become the *raison d'etre* for the innumerable oestrogen-containing beauty preparations which have been marketed in recent years. For these their promoters have made extravagant claims: wrinkles vanish and imperfections disappear, the skin is rejuvenated, the face is kept young and the complexion is made more beautiful. The American Committee was less enthusiastic, however, and cautiously warned its parent body in its Report that a mild degree of epidermal proliferation does not necessarily signify the arrest and obliteration of the blemishes of advancing age; oestrogens were not necessarily a medical 'face-lift'. A recent project by Behrman[2] throws interesting light on this question. Carefully selecting 31 aging women for their integrity in performing and recording the programme, he induced them for a period of 91 days to use an oestrogen-containing preparation for the one side of the face, and an ordinary emollient cream for the other side. His observations were carefully recorded, and his conclusions warrant the notice of all medical readers: 'This study demonstrated that noticeable improvement in the appearance of the skin can be obtained through regular use of an emollient cream on women with dry skins. This study did not demonstrate that the addition of hormones to such emollient bases increased this improvement to any discernible extent.'

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Degree of M.D.: L. van R. Oosthuysen: (Subject of Thesis: 'A study of some aspects of the toxaemias of late pregnancy in the City of Cape Town').

Degree of M.Med.: Miss F. R. Ames. C. N. Barnard.

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PRESENTATION AND PROLAPSE OF THE UMBILICAL CORD

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Presentation and prolapse of the umbilical cord are not infrequent complications of labour. They are not to be considered lightly since, more often that not, the foetus succumbs. Should there be any means of procuring the birth of a live baby in this type of complication, the methods must be thorougly understood and well applied.

It is with this object in view that an analysis has been made of cases suffering from cord prolapse and presentation during the period from 1 January 1948 to 30 June 1953 in the maternity institutions of the University of Cape Town Obstetric Unit. During this period the total number of deliveries amounted to 36,347. Cord prolapse and presentation were present in 203 cases—an incidence of 1 in 179, or 0·56%.

Presentation of the cord was diagnosed in 5 cases. In 4 of these Caesarean section was performed, and in the fifth case—a second twin presenting by the breech—the membranes were ruptured and the infant extracted. All 5 mothers and infants survived.

TABLE I. JANUARY 1948 TO 30 JUNE 1953

Total number of births	36,347
Number of cases of prolapse + presentation	203
Incidence of prolapse + presentation 1 in 179 =	0·56%
Foetal mortality	123
Foetal mortality per 1,000 births	3·4
Foetal mortality as percentage of cases of cord prolapse + presentation	60·6%
Total no. of stillbirths (from all causes)	1,440
Percentage of stillbirths caused by prolapse of the cord	8·5%

Table I shows that the foetal mortality per 1,000 births was 3·4, and that the uncorrected foetal mortality per cases of cord presentations and prolapses was 60·6%. Of the total number of stillbirths occurring over this 5½-year period 8·5% were caused by or associated with prolapse of the cord. There were no maternal deaths in this series. It is clear that this complication of labour plays an important role in the over-all stillbirth rate.

TABLE II

Total number of cases of prolapse + presentation of cord	203
Number of cases in which foetus was alive when condition was diagnosed	131
Number of living children obtained	80
Percentage of living children in total number of cases	39%
Percentage of living children in cases in which foetus was alive when condition was diagnosed	61%

Table II shows how fatal to the infant this complication can be. The percentage of living children obtained in the total number of cases was 39·4%. Of those cases in which the foetus was alive when the condition was diagnosed, 61% survived.

TABLE III. INCIDENCE AND FOETAL MORTALITY RELATED TO ANTENATAL CARE

	No.	%	*Foetal Mortality* *No.*	%
Booked cases	92	45·3	47	51·1
Emergency cases	111	54·7	76	68·5

From Table III it will be seen that more than half of the cases (54·7%) had received no antenatal care. The foetal mortality in these emergency cases was 68·5%, as compared with 51·1% in the booked cases. A lower incidence of prolapse and a higher incidence of foetal salvage in those cases receiving efficient antenatal care is to be expected, a state of affairs reflected in recent reported series. There are factors militating against effective antenatal care, and a constant striving for improvement is most necessary, even under difficult circumstances.

AETIOLOGY

Any condition preventing proper application of the presenting part to the brim of the pelvis will predispose to presentation and prolapse of the cord. The same applies to low implantation of the placenta and an abnormally long cord. The abnormally long cord is of especial importance in the so-called occult prolapse of the cord, i.e. where the cord is compressed against the walls of the pelvis by the presenting part, without actually prolapsing in front if it. This phenomenon accounts for the occasional case of foetal distress where no obvious clinical cause can be found. Here careful examination under anaesthetic may be required for diagnostic purposes.

Since the length of the cord was usually not recorded in this series, the part played by an abnormally long cord could not be determined.

TABLE IV. AETIOLOGICAL FACTORS INVOLVED

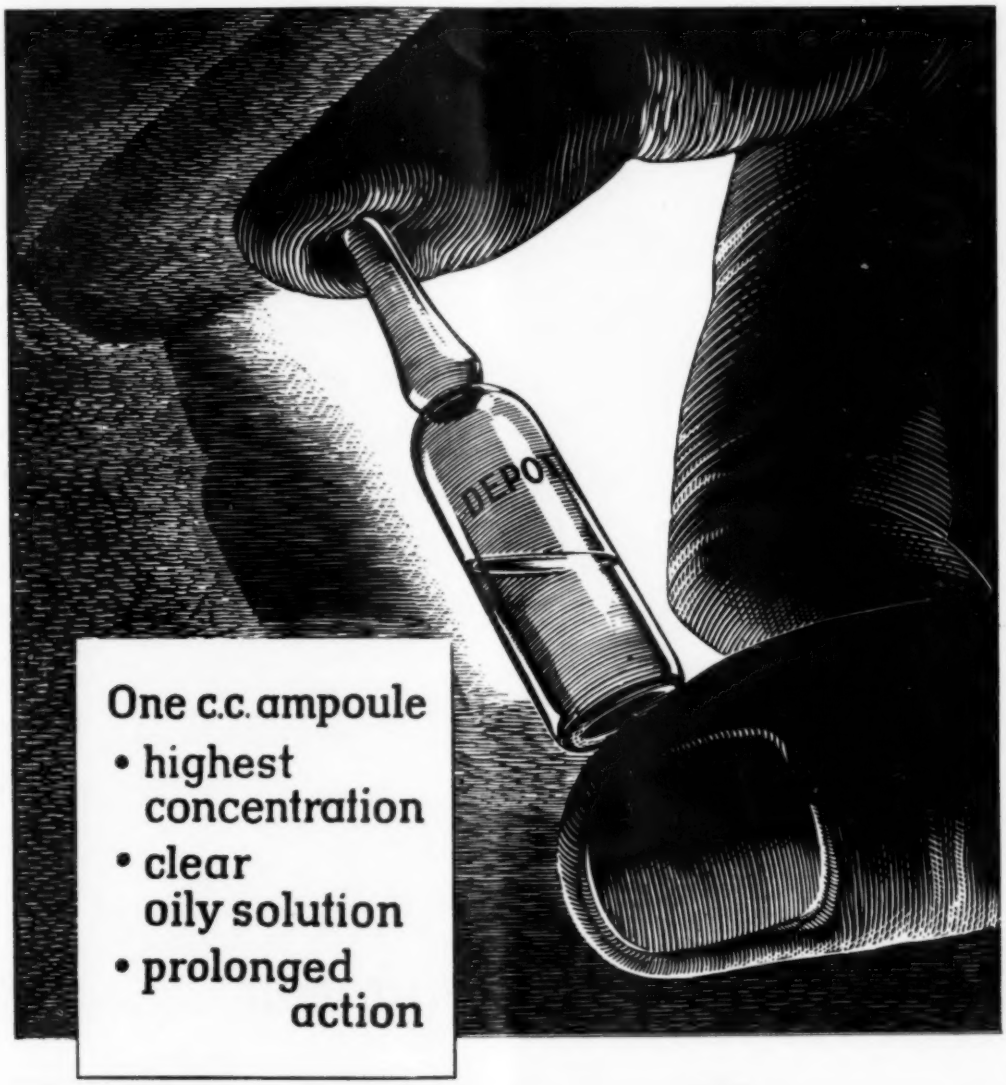
Disproportion	8	3·9%
Occipito-post. + Transverse arrest	9	4·4%
Breech	54	26·6%
Brow	2	0·9%
Face	2	0·9%
Transverse lie	42	20·7%
Placenta praevia	10	4·9%
Hydramnios	2	0·9%
Twins	12	5·9%
High and mobile head	8	3·9%
Compound presentation	11	5·4%
Manipulation	1	0·5%
Prematurity	47	23·2%
Unknown	56	27·6%

The following factors were considered:

1. *Parity.* The ratio of primigravidae to multigravidae was 1 to 4·7. The slight preponderance of parous women is hardly significant.

2. *Disproportion.* 3·9% of the total number of cases was associated with a contracted or deformed pelvis, or an abnormally large foetus.

3. *Malposition and Malpresentation.* These were frequently associated with prolapse of the cord. Thus, these factors occurred in the bracketed percentages: breech presentations (26·6%), posterior position of the occiput and deep transverse arrest (4·4%), brow and face presentations (0·9%), transverse lie (20·7%) com-



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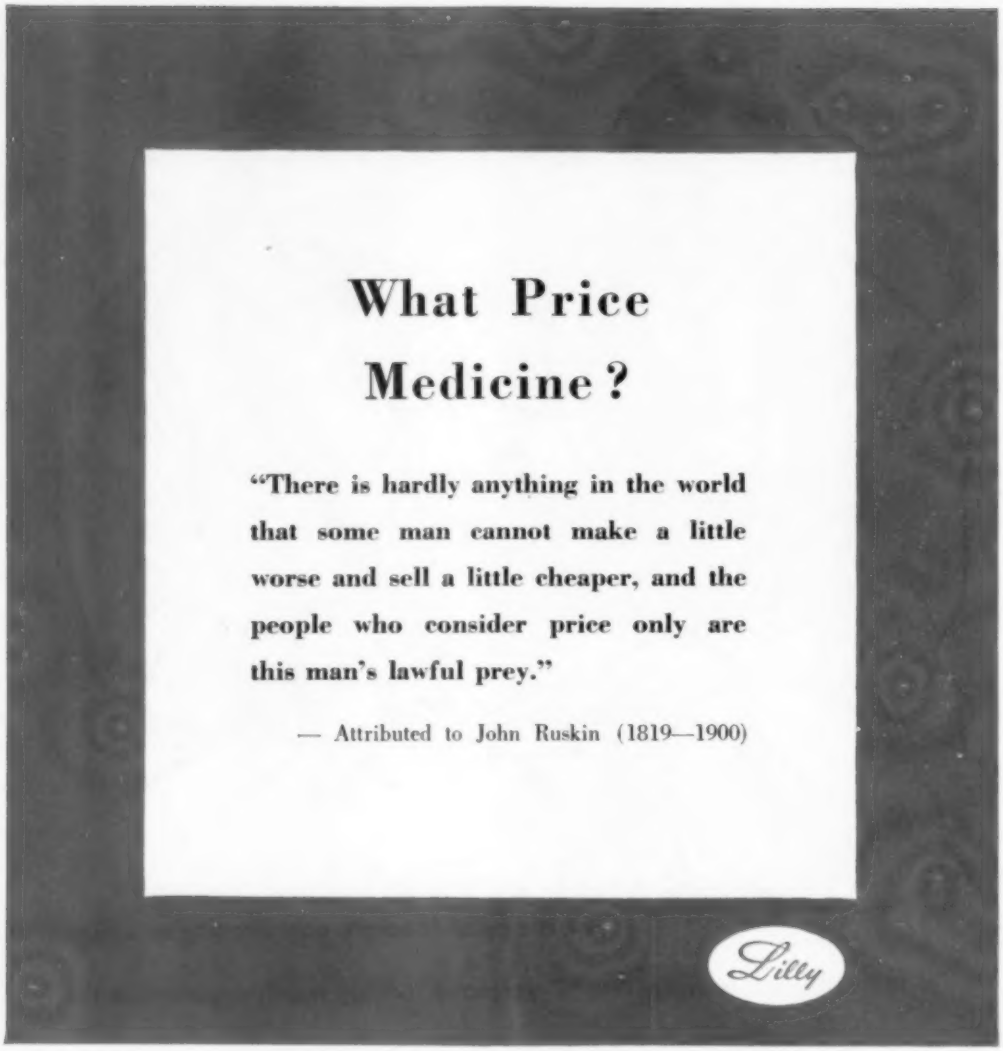
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pound presentation (5·4%). The cause of this malpresentation was mostly obscure and delivery by different means was usually effected without difficulty.

4. *Placenta Praevia.* Although a diagnosis of placenta praevia by palpating the organ or by visualizing it at operation was not always possible, the diagnosis was made on very suggestive signs and symptoms, especially antepartum haemorrhage. The percentage of 4·9% in this series is much higher than the 0·01% of placenta praevia found in all viable confinements, and low implantation of the placenta must be regarded as a significant cause of prolapse of the cord.

5. *Twin Pregnancy.* 5·9% of cases was associated with twin pregnancy. Since the percentage of twin pregnancy in all pregnancies is 1·25%, multiple pregnancy must be regarded as an important aetiological factor. In this series, 4 cases of prolapse occurred with the first twin, and these all presented by the breech. Of the cases in which the complication occurred with the second twin, 1 presented by the vertex, 3 by the breech 1 by the shoulder, and 3 were compound presentations.

6. *Prematurity.* 47 cases in this series were premature, an incidence of 23·2%. This is considerably higher than the 5–8% incidence of prematurity in deliveries as a whole. Most of the cases were associated with breech presentation, twin pregnancy, or placenta praevia. The tendency of the premature infant to present by the breech is significant.

7. *Obstetrical Manipulations.* Only one case of this nature is recorded in the series, but it is possible that it occurred more often. When the outcome of the manipulation is successful these cases are usually not recorded.

8. *Hydramnios.* Since this condition is frequently associated with a mobile presenting part, breech presentation, or prematurity, prolapse of the cord should reasonably be relatively common in this complication. However, in this series it occurred in 2 cases only (0·9%)

9. *High and Mobile Head.* In 3·9% of cases the only feature was a high and mobile head. Subsequent delivery was spontaneous and easy. There was no question of disproportion. Seven of the 8 cases occurred in multiparae.

10. *Unknown.* In 27·6% of cases—all normal vertex presentations—the cause of the prolapse could not be ascertained. The deliveries were straightforward.

PROGNOSIS

The prognosis for the infant is analysed from the point of view of the presentation, the condition of the cervix, and the maturity of the infant.

TABLE V. INCIDENCE OF PROLAPSE OF CORD AND FOETAL SURVIVAL ACCORDING TO PRESENTATION

Presentation	*Number*	*Survived*	*% Survival*
Cephalic	94	33	35·2%
Breech	52	29	55·8%
Transverse Lie ..	42	16	38·1%
Compound	15	2	13·3%

Table V shows that with this condition of the cord the foetal survival rate was highest with breech presentation, followed by transverse lie and cephalic and compound presentation, in that order.

TABLE VI. CONDITION OF CERVIX AND FOETAL MORTALITY

Dilatation of Cervix	*No. of Cases*	*Incidence*	*No. living*	*% survival*
Complete	104	51·2%	46	44·7%
Incomplete	99	48·8%	37	37·4%

Table VI shows that in cases where the cervix was fully dilated, 44·7% of the infants survived, while with incomplete dilatation 37·4% survived. It is to be noted, however that in this series many infants were moribund on admission. Usually when the foetal heart is heard and the os fully dilated the chances of foetal survival are far greater. Thus Kush [11] found that with full dilatation 25% of the infants were lost, while with incomplete dilatation the figure was 72%.

TABLE VII. PREMATURITY AND FOETAL MORTALITY

	No. of Cases	*% of Total*	*Foetal Deaths*	*% Foetal Mortality*
Premature	47	23·2%	35	74·5%
Mature	156	76·8%	80	51·3%

Table VII shows the high foetal mortality when the infant is premature. Of the premature infants 74·5% were lost as compared with 51·3% of the mature babies.

TREATMENT

When the infant is dead, delivery should be effected by the manner calculated to harm the mother least, and this includes destructive operations, should they be necessary. Cessation of pulsation in the cord should not be relied upon alone. A careful auscultation for foetal heart sounds is of vital importance, as the heart may still beat after cessation of cord pulsations.

When the foetus is alive, treatment of prolapsed cord will depend on whether the os is completely or incompletely dilated.

TABLE VIII. TREATMENT IN CASES IN WHICH OS WAS NOT FULLY DILATED, AND CORD WAS PULSATING, WHEN PROLAPSE WAS DIAGNOSED

	L.	*S.B.*	*N.D.*	*Total*
Cephalic Presentation. 28 *Cases*				
Replacement and treatment by posture	1	4	1	6
Bipolar version	1	3	–	4
Replacement and Willett's forceps	–	2	–	2
Caesarian section (L.U.S.) ..	6	–	–	6
Internal version and breech extraction or leg brought down. ..	5	5	–	10
Breech Presentation. 21 *cases*				
Replacement and breech extraction or leg brought down.	11	8	1	20
Caesarian section (L.U.S.) ..	1	–	–	1
Transverse Lie. 13 *cases.*				
Replacement and bipolar version	1	1	–	2
Caesarian section (L.U.S.) ..	4	–	1	5
Internal version and breech extraction or leg brought down ..	2	4	–	6
Compound Presentation. 5 *cases.*				
Replacement and treatment by posture	–	3	–	3
Bipolar version	–	1	–	1
Internal version and breech extraction or leg brought down ..	–	1	–	1

L. = living child. S.B. = stillbirth. N.D. = neonatal death. L.U.S. = left upper segment. Replacement = replacement of cord.

1. *Os not fully dilated.*

(*a*) In 28 cases the *vertex* presented. In 6 of these replacement of the cord with postural measures was the treatment adopted. Only 1 infant survived (2 were actually born alive, but 1 died subsequently.) Bipolar version was performed in 4 cases, but only 1 infant survived. Two cases were treated by replacement of the cord and the application of Willett's forceps with continuous traction; both infants were stillborn.

In 10 cases the os was sufficiently dilated to allow internal version and breech extraction or traction on the leg that was brought down; 5 infants survived.

Caesarean section was performed in 6 cases, and all the infants survived.

(*b*) Prolapse of the cord occurred with a *breech* presentation in 21 cases. The os was ¾ or more dilated in 20; in *these the* cord was replaced, a leg brought down and traction applied to the foot of the foetus, or the infant was extracted; 8 of these babies were stillborn and one died in the neonatal period. The remaining case underwent Caesarean section and the baby survived.

(*c*) 13 cases presented with *transverse lie*. In 2 of these cases the cord was replaced, bipolar version performed, a leg brought down and traction applied; 1 infant survived and 1 was stillborn.

In 6 cases the os was sufficiently dilated to allow of internal version and leg traction or breech extraction; 4 of the infants were stillborn.

Caesarean Section was performed in 5 cases, and all the babies were delivered alive. One case was complicated by placenta praevia in addition, and the infant (3lb. at birth) died in the neonatal period.

(*d*) *Compound* presentation occurred in 5 cases. Three of these were treated by replacement and postural measures, and all 3 infants were stillborn. In one case bipolar version and leg traction was the treatment adopted, but the infant was stillborn. In the other case, dilatation of the os allowed of internal version and continuous leg traction; the infant was stillborn.

Discussion. In the interests of the infant it is unwise to await further dilatation of the cervix. The results of obstetrical manipulations are on the whole poor, the best occurring in breech presentations. Even in these, the foetal loss was almost 50%.

Caesarean section gave by far the best results; 12 cases were treated in this way, and all the infants were born alive. (One baby died subsequently, but it was very premature and the Caesarean section was done primarily for a concomitant placenta praevia.) All the mothers recovered normally. Authorities differ in opinion over the place of Caesarean section in this complication. Munro Kerr and Chassar Moir[1] regard it as a radical form of treatment, to be instituted only in cases of presentation of the cord recognized early on in labour: 'We advocate this procedure in (*a*) elderly primiparae, (*b*) when there is any co-existing abnormality in the pelvis, (*c*) faulty presentation (face, brow or shoulder), (*d*) if the child appears of large size'. Baird's Combined Textbook[2] states: 'Even in hospital practice the field for Caesarean section is limited, since the emergency is often so acute that there is little time to prepare an operating theatre. Practically, it is almost restricted to the case in which some complication is present, or to a childless patient in whom the foetal heart continues to beat long enough to allow of operation'. Eden and Holland[3] state simply that 'under certain circumstances, Caesarean section may justifiably be proposed to save the life of the foetus', but they do not enlarge up on this statement. Gibberd[4] shares these conservative veiws. He employs Caesarean section only in certain selected cases, or where some other abnormality exists. Eastman[5] states that 'Caesarean section is indicated in a few of these patients, particularly elderly primigravidae and those in whom a subsequent pregnancy appears undesirable'. In an excellent review of the subject in 1951, Cope[6] favours Caesarean section when the os is ½ or less dilated. He states, however, that in his series equally good results were obtained by prelacement and application of Willett's forceps when the foetus was mature. Earlier reviewers—Mengert and Longwell[7] and Bourgeois[8] did not favour Caesarean section except in selected cases.

In a review published in 1951, Fenton and D'Esopo held early diagnosis and rapid delivery to be important, since a striking increase in foetal mortality occurred when the time interval between diagnosis and delivery was prolonged from ½ to 1 hour. After 3 hours, the foetal mortality rate reached 70%. Thus, when the cervix was less than 7 cm. dilated, and the infant not distressed, prompt Caesarean section seemed to be the safest method of delivery. They also observed that—transverse presentations and true cephalo-pelvic disproportion excepted—women with high presenting parts in whom the membranes have ruptured should be out of bed, since prolapse apparently occurs more readily in the recumbent position.

Greenhill[10] holds that when the cervix is half or less dilated, Caesarean section offers the best chances for the foetus but when dilatation of the cervix is complete or nearly so, it is best to deliver the baby *per vaginam*.

Kush,[11] in 1953 analysed 105 cases, 9 of which were dealt with by Caesarean section; only one infant was lost and this was associated with premature separation of the placenta. Kush made a plea for the more liberal use of Caesarean section in the treatment of this condition.

In competent hands and in a well-appointed hospital, Caesarean section is today a relatively safe procedure. Prolapse of the cord, when the os is less than ¾ dilated, carries an excessively high foetal mortality. The attendant who has to deal with a prolapse and an os not fully dilated should indeed have good reason for choosing any other form of delivery. In fact, the only contra-indication to Caesarean section should be a moribund foetus.

TABLE IX. TREATMENT IN CASES IN WHICH OS WAS FULLY DILATED, AND CORD PULSATING, WHEN PROLAPSE WAS DIAGNOSED

	L.	*S.B.*	*N.D.*	*Total*
Cephalic Presentation 28 cases.				
Spontaneous Delivery	12	3	–	15
Forceps	2	3	1	6
Internal version	2	1	1	4
Caesarian section	–	–	1	1
Destructive operations				2
Breech Presentation. 22 cases.				
Assisted breech delivery	2	2	1	5
Breech extraction	11	6	–	17

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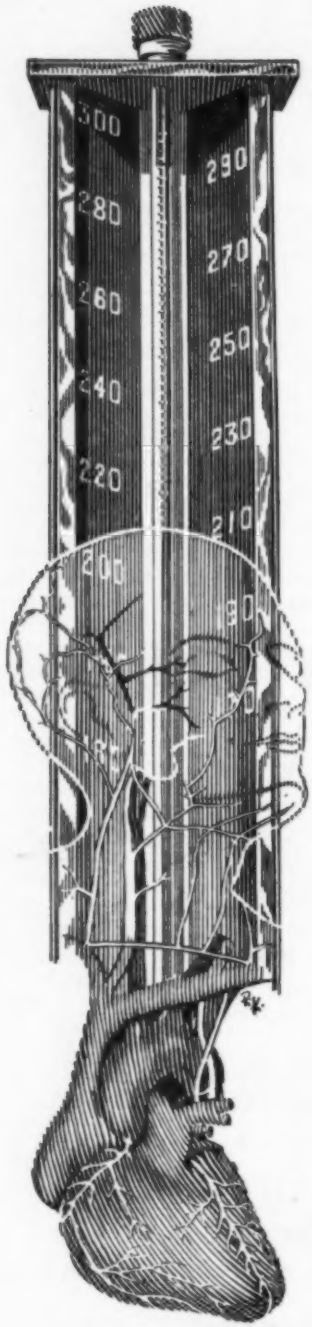

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	L.	S.B.	N.D.	Total
Transverse Lie. 9 cases.				
Internal version and breech extraction	5	1	1	7
External version and spontaneous delivery	1	–	–	1
Spontaneous version and spontaneous delivery	1	–	–	1
Compound Presentations. 5 cases.				
Spontaneous delivery	–	1	–	1
Forceps	1	–	–	1
Internal version	2	1	–	3

L. = living child. S.B. = stillbirth. N.D. = neonatal death.

2. *Os fully dilated.*

(*a*) The *vertex* presented in 28 of these cases. In 15 delivery occurred spontaneously. In these, the head was low in the pelvis or on the perineum when the condition was diagnosed, and while preparations were made for the application of forceps the patient was encouraged to bear down. Delivery was usually rapid, and 12 of the babies survived.

In 6 cases forceps were applied, but delay in preparing the instruments and anaesthetizing the patients resulted in 3 stillbirths, and another infant died in the neonatal period. When the station of the head in the pelvis was too high for safe forceps delivery, internal version and breech extraction was performed. In the 4 cases of this nature, 3 infants were delivered alive, but 1 died in the neonatal period.

Caesarean section was performed in one case. This was a case of cephalo-pelvic disproportion, complicated by prolapse of the cord. The infant was extremely asphyxiated at birth and died 2 days after delivery.

In 2 cases the cord pulsated feebly at the commenecment of operative delivery. Difficulties were encountered, and as the cords had ceased pulsating, craniotomy was considered the safest form of delivery for the mother.

(*b*) The *breech* presented in 22 cases. In 5 of these the patient was allowed to deliver herself with assistance to the aftercoming head, but only two of the infants eventually survived. In 17 cases the breech was extracted as soon as possible, resulting in 11 live births.

(*c*) There was a *transverse lie* in 9 cases. In 7 of these, internal version and breech extraction was performed, resulting in 1 stillbirth, 1 premature baby who died in the neonatal period. External cephalic version was carried out in one case and the patient allowed to deliver spontaneously; surprisingly, a live child was born. In one case spontaneous rectification and delivery of a live infant occurred.

(*d*) There was a *compound* presentation in 5 cases. Spontaneous delivery of a stillborn infant occurred in one case. In another, replacement of the arm and cord and forceps delivery was performed, and the infant delivered alive. Internal version and breech extraction were carried out in 3 cases, 2 of the infants being born alive.

Discussion. Most authorities are agreed that when the cervix is fully (or almost fully) dilated, the infant should be delivered *per vaginam*. It is usually unnecessary to replace the cord first. Where the vertex presents, and conditions for the safe application of forceps are fulfilled, delivery should be by this means. In other cases, delivery should be effected by internal version and breech extraction, providing these manipulations are allowed by the state of the uterus. It is said that with the breech presenting there is less danger of fatal compression of the cord, on account of the soft and irregular outline of the breech. However, it is unreasonable to take risks with the life of the baby when the os is fully dilated, and breech extraction should be promptly performed.

Transverse lie is dealt with by internal version and breech extraction, again providing the state of the uterus allows this to be done with safety for the mother. A uterus tightly contracted on a living child is best treated by Caesarean section.

A compound presentation should be dealt with by the manner judged safest for the mother and child. Replacement of the hand or foot and forceps delivery, or internal version and breech extraction, will meet the demands of most cases.

CONCLUSIONS

1. Many cases of prolapse of the cord occur with one or other malpresentation, but careful antenatal care will eliminate this factor almost completely, and will allow earlier diagnosis and treatment and disproportion.

2. In cases of suspected placenta praevia undergoing expectant treatment in hospital, the possibility should be remembered of prolapse of the cord as an additional complication.

3. Prolapse of the cord frequently accompanies twin pregnancy and prematurity.

4. Should the head be high and mobile, the possibility of prolapse of the cord should be kept in mind. A vaginal examination should be made immediately after the membranes have ruptured. The same applies to artificial rupture of the membranes for the induction of labour.

5. In all cases of unexplained foetal distress during labour a careful examination—if necessary under anaesthetic—should be made. Occasionally a case of occult prolapse of the cord will be diagnosed.

6. In a well-equipped hospital, facilities for dealing with this complication should always be available. Cases occurring outside hospital should be dealt with by a 'flying squad'. Emergency treatment should be directed towards preventing pressure on the cord, not only by postural treatment but also by actively holding up the presenting part with two fingers in the vagina. The administration of oxygen and coramine to the mother may be of some value.

SUMMARY

1. 203 cases of presentation and prolapse of the umbilical cord are analysed.
2. Recent trends in treatment of this complication are discussed.
3. Some general remarks regarding the prevention, early diagnosis, and emergency treatment of the condition are made.

I wish to thank Professor J. T. Louw, Head of the Department of Obstetrics and Gynaecology, University of Cape Town, for his

constant helpful criticism, and the Superintendents of the hospitals concerned for permitting the analysis of there cases.

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PRACTICAL ANAESTHETICS IN GENERAL PRACTICE

G. G. AIREY, M.R.C.S., L.R.C.P.
and
J. N. BARNARD, M.B., B.CH.
Sir Henry Elliott Hospital, Umtata

To many is afforded the opportunity for 'giving dopes'; some of these have the flair for administering a good surgical anaesthetic; but to very few is it given to combine a good anaesthetic from the surgeon's point of view with one from which the patient suffers the least amount of shock and other unpleasant after-effects.

It is unnecessary to say that without a good anaesthetic the surgeon's work becomes difficult, if not impossible. He should not have additional anxieties thrust on his shoulders in difficult cases by heaving abdomens and blue patients, and coils of writhing bowel, to say nothing of other unpleasant 'incidents'.

If anaesthetics *can* be taught, which we doubt, then, from the newly-qualified housemen we have seen, it can be said that in every teaching hospital, without exception, it is a badly-taught subject. To us it has seemed that the ability to give anaesthetics is a gift, and that without this gift the student can never be taught. It is a gift which includes a great degree of self-confidence. The man who approaches anaesthetics without controlled self-confidence is a lost man; it is his patients that will develop laryngcal spasms and hover between life and death for the remainder of the anaesthetic. We have used the word 'controlled', because obviously the doctor who approaches his case in a mood of blind confidence is also lost, and will most likely find himself in a coroner's court. From our experience we think it can be said of the newly-qualified doctors who obtain posts here that their training in anaesthetics only starts with their advent to our hospital. We say this in all humility, for their practical knowledge in this branch has been almost nothing—possibly the result of the routine 20 anaesthetics'under supervision' in a general hospital.

ANAESTHETIC PROCEDURE

The first rung on the anaesthetist's ladder is his initial approach to the patient. He should try to see the patient the night before the operation, to gain his confidence and allay his fears. In the unnatural surroundings of a hospital these strange apprehensions are magnified a hundredfold by the patient, to whom an operation is second only to the atomic bomb. It is most important that the patient should realize that the doctor is not a coldly scientific machine but a warmly sympathetic human being, who has been given the privilege of guarding the lives of others.

The anaesthetist should watch carefully the positioning of the patient on the table, guarding against the possibility of the arms hanging loosely over the sides. Dislocated shoulders and musculo-spiral paralysis have occasionally resulted from such trivial mishaps. Bony prominences, e.g. elbows, must not be allowed to lie against metal screens without intervening wool. We have thought that pillows should be placed in the lumbar hollow. Often the patient complains bitterly of backache after the operation and it has been suggested that this is the result of flattening of the normal lumbar curve due to relaxation and stretching of muscles and ligaments. Care should be taken, too, when lifting the patient on and off the table to see that the head is supported. Too often one finds that the canvas stretcher does not support the head.

We have, as a routine, used premedication with nembutal and atropine, and have found this very satisfactory.

On the patient's arrival in the theatre, the anaesthetist should see that there is as little extraneous noise as possible, such as the clatter of instruments and dishes. He should check his apparatus over to see that all valves are open and that the cylinders are full. Before beginning to administer the anaesthetic he should see that all instruments, tubes, syringes and laryngoscopes are ready to hand and in working order.

We have used Pentothal 5% for induction purposes; the amount used varies between 6 and 12 c.c. This we have followed by Scoline in suitable doses for the weight of the patient. A word as to intubation: It should be

remembered that the patient has teeth, or at least very delicately structured gums. So many doctors insert a laryngoscope as if it was a spade, and with just as much force, extracting teeth and harrowing gums—going on then to stripping up the mucous membrane of the pharynx with the point of the laryngoscope. All this is as a result of hurrying; the doctor should work deliberately, with deceptive slowness, and complete confidence.

If the patient is edentulous the anaesthetist should cover the gums with a swab so as to cushion them against the instrument. One of us prefers to work with a Mackintosh laryngoscope, which retracts the tongue laterally and has a blunted end which, by virtue of the curved spatulate portion, fits into the vallecula, thus, on pressure upwards and forwards, holding the epiglottis out of the way and exposing the cords. We have thought that other types of laryngoscope tend to exert too much pressure directly on the posterior surface of the epiglottis, possibly bruising it.

We do not like intubating blindly, preferring to pass the tube directly into the trachea under direct vision. The tube chosen should err on the small side; one is then less likely to damage the cords or to cause a pressure-necrosis—a not very distant contingency with an oversized tube. The tube should not be passed far down the trachea for the bifurcation of the trachea is not more than 4 inches distant from the cords. This is a mistake which can easily occur, since tubes come from the suppliers in unsuitable lengths which one is apt to think are normal.

We have preferred to use rubber tubes instead of the latex variety. The latter have sharp and hard points and are not so pliable; they are apt to cause damage in the naso-pharynx when used intranasally.

The size factor should be borne in mind also when using tubes with inflatable cuffs. It is better to err on the small side. Before using these cuffs it is a good idea to put the tube into a pipe roughly the diameter of a trachea and then to inflate the cuff and to list the tensity of the control bulb. We have thought it good practice even then to release the air from the cuff at intervals so as to be sure that there can be no prolonged pressure on the mucous membrane lining the trachea, and thus to obviate the possibility of a pressure-necrosis.

Having safely inserted the tube, which is held in place by strips of adhesive plaster, the anaesthetist then performs artificial breathing by hand pressure on the bag of the machine, with the valve on the corrugated tube *open*, so that the lungs are not forcibly expanded—a factor which may tend to a pneumothorax. Directly voluntary regular breathing is established the anaesthetic can be started. It might be necessary to inject one or two c.c. of Pentothal, if the patient shows any sign of restlessness. One of us (G.A.) has a preference for cyclopropane and the other (J.N.B.) has a preference for gas and oxygen. When the surgeon is due to open the peritoneum we have used Flaxedil as the relaxant of choice so far as we general practitioners are concerned. It is relatively short-acting, it is true, but the dose can be repeated, and it does not have the same prolonged respiratory depressent effect as curare and seems to be safer in the hands of those who are not specialist anaesthetists. If its effect wears off at the close of an operation we have used small doses of scoline for the stage of sewing up the peritoneum.

Using this method in more than 4,000 cases (G.A.) and 600 (J.N.B.) we have found it eminently satisfactory. The patients have recovered consciousness almost immediately and have shown no signs of shock, nor have they suffered from post-operative vomiting; and there have been the minimum number of post-operative chest complications. The rapidity with which patients recover means, too, less work for the ward staff since they do not have to wait indefinitely for patients to recover—not a small consideration in these days when nurses are at a premium, and their scarcity throws extra work on the reduced staffs.

We have not liked using ether as an adjuvant because a small taste of ether goes a very long way, and both of us have at various times suffered personally. Where it has been necessary we have used it, but not as a routine, because there has been more post-operative coughing and vomiting than with other anaesthetic agents. Chloroform we *very* rarely use, considering it dangerous.

SPECIAL OPERATIONS

Thoracic Surgery. One of our partners has, for some time, been occupied with surgery of the thorax, with particular reference to carcinoma of the oesophagus, for which he has successfully operated on several cases, doing a partial oesophagectomy with oesophago-gastrostomy. One of the writers has interested himself in the anaesthetic aspect of these cases, and has used a routine of Pentothal-Scholine-Flaxedil and light cyclopropane delivered through a Mushin apparatus. This has involved controlled respiration in order to facilitate the surgeon's manoeuvres, and inflation of the collapsed lung at intervals through the operation. It is a relatively simple anaesthetic to give and it may be that other doctors in similar circumstances may find encouragement and be able to tackle similar work. All the cases have afterwards been very satisfactory, and their only complaint has been the intravenous drip. This is probably the most relevant place to express the opinion, which we do without hesitation, that the anaesthetist is concerned only with his anaesthetic and should not, on any pretext, be involved in last-minute 'cut-downs' for intravenous fluids. Whatever the temptation to help, it should be resisted, and the temptation can be great when assistance is not immediately available or the theatre nursing staff has just been changed. His attention must not be distracted from his main function—we have seen near-catastrophes happen in this way.

Caesarean Section. We have many times been concerned with the best anaesthetic to give for Caesarean sections. So much depends on the speed of the operator. Where the latter is rapid, and the patient is completely painted and towelled and everybody is in readiness, use Pentothal as an induction agent, followed by gas and oxygen or cyclopropane. Directly after extraction of the baby, scoline is given, the patient intubated, and then the inhalation anaesthetic continued, with Flaxedil as a relaxant. Where the operator is slower we use cyclopropane for induction and, after extraction of the baby, intubate with aid of scoline and continue with light

cyclopropane anaesthesia and Flaxedil as a relaxant. In no cases have we been unfortunate enough to see the condition described as 'cyclopropane shock'; there were some cases in which directly the cyclopropane was started the pulse became irregular, but this rectified itself directly the anaesthetic was changed.

Tonsillectomy. For tonsillectomy in children our method has been to sedate them adequately with Nembutal an hour beforehand, use ethyl chloride, for induction, and then to give oxygen and ether through the Boyle-Davis gag.

Responsibility. Here one might mention the vexed question of responsibility, as between surgeon and anaesthetist, for swabs used during operations on the nose or throat. It has appeared to us that this is the surgeon's or the dentist's responsibility, because the anaesthetist is fully occupied with the maintenance of anaesthesia and cannot keep count of swabs inserted into the patient's mouth. He cannot be held responsible for a surgeon or a dentist who might pick up two swabs instead of one by mistake. We should be glad to know exactly what the ruling is in these cases, for the authors available to us are obscure in this matter. Our own practice is to state clearly to the surgeon or dentist that we are not responsible for oral or nasal swabs.

TRAINING

It has seemed to us that anaesthetic technique such as we have described can be carried out by any intelligent man who has been adequately trained. The operative words are, of course, 'adequately trained', and this is where our teaching hospitals fail. No house surgeon who has come to this hospital could be so described, but we have found that after 6 months here he can give an excellent and perfectly safe anaesthetic, using the agents we have described. We have encouraged them to watch us and to 'absorb' the technique, rather than 'teach' them and we have then supervised them until we have felt they could be trusted. We do not believe that you can 'teach' anaesthetics. You can teach a man how machines work, what the physioligical effects and chemistry of the various agents are, but between these fixed facts and the human variants lies a world of difficulty. The process must surely be one of 'absorption,' allied to a keen perception and observation. The teaching hospitals teach, and students are 'qualified' to give anaesthetics after attending lectures and giving 20 supervised anaesthetics. And their results are, in our experience, appalling. Some hospitals have banned the use of relaxants in the anaesthetic departments; but what avails that, and to withhold the demonstration from students, when they can give just as lethal an anaesthetic with the so-called 'safe' agents? The whole crux of the matter lies in the training; we use the word 'training' advisedly. Relaxants have come to stay and students should be familiar with their use.

We feel that we turn out from this hospital men better able to administer anaesthetics safely than the teaching hospitals do. Surely this is wrong. It is true that the numbers we deal with are limited, but surely some scheme could be devised in the larger centres to ensure better training in this branch. After all, the present system was in vogue when one of the present writers qualified twenty years ago. Have we made no advance since then?

CONCLUSION

The purpose of this article is two-fold:

1. To show that general practitioners can, with complete safety, administer modern anaesthetics. (In this connection we should like to point out that in almost 5,000 cases, we have had only one fatality during an anaesthetic and that was an extremely bad risk case with liver failure, who had a stone impacted in the common bile duct and was deeply jaundiced and very ill.)
2. To make a plea for the better training of students in our teaching hospitals with regard to modern anaesthetic procedures. We ought to train students as if there might be war tomorrow—when patients and surgeons alike will perforce have to depend for their good results and minimum hospitalisation on good anaesthetists.

We should also like to suggest to the teaching hospitals that they make more provision in their post-graduate sessions on Anaesthetics for those of us to whom the large centres of teaching are not immediately available.

SUMMARY

The intention of this article is to show that general practitioners can practice modern anaesthesia with safety where the facilities exist. In many cases they have had to acquire their knowledge only by practical experience.

We have also made small suggestions, seemingly trivial and obvious, but important nevertheless. The text-books on anaesthesia do not mention them.

A plea is made for the re-organization of the training of students in this branch of medicine. We feel that the 'absorption' technique should be followed, rather than teaching; and that it is most important that students should learn by experience while in a teaching hospital.

A further suggestion is made that teaching hospitals should make available more facilities in their post-graduate courses on anaesthesia for those of us 'in the outer darkness'.

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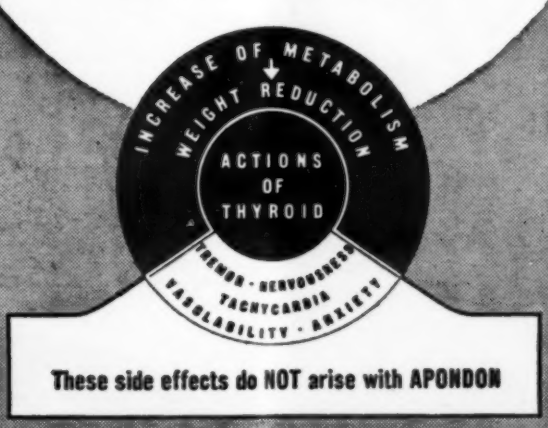

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(*Director, Department of Clinical Research, University College Hospital, London*)

Radioactive isotopes, which are produced by neutron irradiation in atomic piles, or extracted from the waste products of nuclear fission, or derived from the bombardment of targets in the cyclotron, are influencing many aspects of medical research and certain forms of treatment. Their peculiar merit is that, while undergoing exactly the same metabolism as ordinary matter, they can be traced through the body with great sensitivity, using suitable instruments, or, when larger amounts are employed, useful radiation effects can be caused in certain parts of the body.

The high sensitivity of detection of radioactive isotopes makes it possible to observe the dynamics of many physiological processes without disturbing the equilibria being measured. Radioactive iron, for example, is used for determining whether a particular type of anaemia is due to the failure of the iron to be absorbed from the diet, or to the iron being absorbed but not properly used in the haemoglobin and the red cells. More complex chemical compounds, or even organic structures, are 'labelled' with radioactive atoms and their metabolism studied. Thus, penicillin can be made containing a radioactive sulphur atom, or vitamin B_{12} with radioactive cobalt, or blood cells with radioactive chromium. The problems studied with such labelled compounds include the formation of bones, abnormalities of salt excretion in adrenal diseases, the mechanism of conduction of impulses along nerves, the formation and repair of teeth, the function of the thyroid, and the metabolism in the body of steroid, peptide and carbohydrate molecules. In most of these fields the skilful use of radioactive isotopes yields information which could not otherwise have been obtained.

Measurements on patients are not limited to tests depending on the removing of body fluids; they can also be made *in situ* and are of much value to the surgeon in the operating theatre. In fractures of the head of the femur the question of whether the blood supply has or has not been abolished can be answered by injecting radiophosphorus a few hours before the operation and measuring its relative concentrations in the head and shaft of the bone. Radiophosphorus in also used during operations on brain tumours to indicate the extent of operation necessary. By intravenously injecting small amounts of radiosodium solution and measuring the activity with counters placed on the skin, the velocity of the blood flow in the veins can be measured in conditions where thrombosis is likely to occur. The same method can be employed in measuring the speed of blood circulation around the whole body, or through the lungs alone. The dosages used in these investigations are so small that the irradiation received by the body during any of these tests is less than that received in ordinary X-ray examinations.

Turning to the use of radioactive isotopes in treatment, the aim is to deliver the maximum dose to the places to be destroyed with the minimum dose anywhere else. In one type of treatment the isotopes are applied externally or into body cavities. Thus, skin lesions are treated by applications of sheets of plastic impregnated with radiophosphorus. Cancers involving the bladder lining can be treated with a solution of radiobromine contained in a distensible bag which can be inserted into the bladder. If a suitable colloid is introduced into a cavity in the body it will diffuse out only very slowly, if at all. The linings of the abdomen and of the chest may become involved with growth, causing distention of these cavities with fluid; the surface layers of such growth may be selectively irradiated by the introduction of a colloidal suspension of radioactive gold into the cavity.

Quite a different technique is to inject colloidal gold particles of appropriate size into the bloodstream, which will carry them until they are arrested in the fine capillaries of the lung. In this way it may be possible to treat cancers of the lung. Another possibility is to use the technique of cardiac catheterization, in which a fine tube is passed along the vein, through the heart and into an artery which feeds that part of the lung where a cancer has developed. Radioactive colloidal gold is thus located mainly in the region where the cancer is. If the particles are made small enough they will pass through all the lung capillaries and eventually be absorbed by the reticulo-endothelial cells, most of which are in the liver. This provides a method of irradiating the liver only, which may prove useful in treating certain types of leukaemia and cancer of the liver.

By making use of the chemical properties of the radioactive substances it is also possible to deposit the radioactive isotopes where required. The classic case is the treatment of toxic goitre merely by giving the patient a drink of water containing less than one ten-millionth of a gram of radioiodine. In some cases of cancer of the thyroid the secondary deposits can be induced to take up iodine in the same way as normal thyroid tissue. Hence, multiple deposits can be treated with radioactive iodine when they are too widespread for surgical removal.

Although the medical applications of radioactive isotopes are barely ten years old, they have already been developed for tests of the very highest value in research and of great convenience and some importance in routine clinical medicine. Their most important value lies in the clearer understanding that they are giving us of the body processes involved in health and disease, and in this type of investigation they are proving to have an increasing scope and power which is transforming many lines of medical investigation.

* Summary of a lecture by Dr. E. E. Pochin, being the fifth of the series of public lectures arranged by the Atomic Scientists' Association and the Department of Extra-Mural Studies of the University of London. Reprinted from *Nature*, 10 April 1954

COLLEGE OF PHYSICIANS AND SURGEONS OF SOUTH AFRICA

(*Contributed by the Secretary of the Steering Committee*)

The idea of creating a College of Physicians and Surgeons in South Africa has been present for some time and certain members of the medical profession have been working on it for the past 3 years.

During the initial stages all members of the profession resident in South Africa were notified and given an opportunity to join as Founders. About 400 signified their willingness to do so and contributed money to its foundation. On 3 and 4 May this year, the Inaugural Meeting of Founders was held in Johannesburg to discuss the Constitution of the proposed College and during that meeting a Steering Committee was elected so that the Constitution might be framed and the College inaugurated.

IS THE COLLEGE REALLY NECESSARY?

The question has been asked by many people whether on the one hand the College will fulfill a need in South African medical practice or whether on the other hand it will be redundant. Some regard it as a copy of overseas Colleges and wonder whether the formation of a College in South Africa is merely an attempt to foist home-produced goods on an already overcrowded market.

The answer to this fundamental question lies in the Constitution and the purposes of the College. The College will have the power to prescribe post-graduate study and examine and grant diplomas to post-graduates, in order that they may become recognized for professional purposes as having reached certain academic and clinical standards. At present the degrees and diplomas of our Universities are accepted by the Medical Council for this purpose, whereas the true functions of a University should be academic rather than professional. The Council of the College will be elected by the Founders and Fellows, and therefore, through the College, the profession will be responsible for professional standards of post-graduate qualifications.

The College has another important function to fulfil in helping to organize the courses of post-graduate study. This was stated at the Inaugural Meeting, but it should not be taken to mean that the College will be in competition with the Universities. The University centres of medicine are at present confined to 4 towns of the Union, and in other areas there are able practitioners working in hospitals and other institutions, who by reason of their erudition and experience are well able to take part in the post-graduate education of their younger colleagues. The College will encourage local efforts to improve the general standard of practice.

COMPOSITION OF THE COLLEGE

The College will not only include physicians and surgeons in the narrower sense, but is empowered to create faculties in all branches of medicine. Faculties in obstetrics, anaesthesia and other departments of medicine are contemplated.

HAS THE GENERAL PRACTITIONER ANY PART IN THE COLLEGE?

This important question was raised at the Inaugural Meeting and it was unanimously agreed that those general practitioners who had joined as Founders would have equal rights with specialists as candidates and voters in Council elections. The College undoubtedly needs the support of this the largest and most important group of medical men in the Union, and it is by their co-operation and good will that the College will grow and prosper.

With regard to the question of examinations, it is intended that these should be naturally open to any practitioner who has been in practice for 4 or 5 years and feels himself able to take the particular examination. If a practitioner has a special leaning towards some section of medicine or surgery and feels that he would like recognition of his work in this field, then he can by paying the fee sit the examination. It may be that a general practitioner, while continuing his practice, may have done considerable surgical or anaesthetic experience, and feel that his reading is sufficiently wide to stand before the Fellows of the College and apply for admission by examination. By so doing he will enhance his reputation and he will have received recognition for the work he has carried out.

Subject to the provisions laid down by the Medical Council, the diplomas of the College will most probably be recognized as qualifying examinations for those who wish later to become specialists.

HOW DOES IT HELP THE YOUNG GRADUATE?

The young graduate of a medical school in South Africa who wishes to practice surgery at present must continue his studies in the same University for a further period, in order to gain sufficient experience to sit the examination of Mastership in Surgery. This means that throughout his surgical study until he qualifies as surgeon he is instructed by the same group of teachers. Now the teachers of surgery and medicine in our Universities are able men, but if a graduate is going to have his views entirely moulded by the same group of teachers throughout his training, he is going to leave his school with a definite bias. The examinations of the College will be conducted by practitioners from all over the country, some of whom have been trained overseas in different countries. Because of this, the candidate for the post-graduate diploma must adopt a much broader view of the subject which he studies in order to satisfy the examiners. This will undoubtedly raise the standard and broaden the basis of post-graduate work.

The graduate of a University in medicine may not be able, either for financial or other reasons, to continue in the University hospital as a post-graduate student; he may have to go out into general practice. Here he can still continue his studies, because certain other hospitals will be recognized by the Council of the College as training centres for the diplomas. Consequently when this graduate feels himself sufficiently advanced, he can apply to the College and present himself for examination.

In the first instance all Fellowships and diplomas of the College will be granted only by examination. It was laid down quite clearly at the Inaugural Meeting as the unanimous view of those present that no member was to receive a post-graduate degree in return for his subscription. It was laid down that Honorary Fellowships would not be given to practitioners who might make use of them for professional purposes; there was to be no 'buying' of diplomas.

EXAMINATIONS

The examinations will most probably follow the models of college examinations in Britain, the Commonwealth and the United States of America. In these examinations there are many examiners. After completing the written part of the examinations, a candidate is examined orally in the several tests at which there are two examiners present. These examiners will be drawn from all over the Union. They will be specialists in the particular field of their examination. This method makes for impartiality and the maintenance of a uniform high standard throughout the Union.

REPUTATION OF THE COLLEGE

The reputation of the College will depend upon its Fellows and Members. There are Colleges of Surgery and Medicine in the United States, Great Britain, Canada and Australia. It is hoped—and it is most probable—that the South African College will receive reciprocal recognition with these other Colleges, and thus enable South African graduates with diplomas who wish to travel to be recognized elsewhere as of sufficient standing to undertake particular courses in post-graduate study.

THE ATTITUDE OF THE UNIVERSITIES

It has been rumoured that our medical schools are opposed to the formation of this College. My experience is limited to the University of Cape Town, and here we have received encouragement and support from the beginning.

The position of the University with regard to the College has been made abundantly clear. The College itself will be responsible for the standard set in post-graduate education. The University will, by its ability to teach, provide where necessary courses which enable the graduates to sit the examinations for the College. However, graduates may not require courses for all types of examinations and may be able to work on their own and achieve a sufficient standard. The Universities, on the other hand will undoubtedly provide courses of training to enable candidates not so well placed to achieve their aim.

THE POSITION OF THE FOUNDERS

Before the Inaugural Meeting on 3 May 1954, it was intended that there should be Founder Fellows and Founder Members, but this proposed differentiation has now fallen away, and all groups of the medical profession, who were represented there, came together in one body as Founders with equal rights and privileges.

The atmosphere of the meeting was charged with sincerity, and all professional men present had clearly the object of building for the future.

When the College is inaugurated and the lists again thrown open for Associate Founders, the profession will realize the selfless spirit which has initiated this College. No member came to the Inaugural Meeting with the intention of acquiring anything in return for his labour or subscription, other than the privilege of assisting to initiate something that we hope will endure. The Royal College of Surgeons in England, following up on the Surgeons' Company, was inaugurated in 1800, and since that time it has steadily progressed. The Edinburgh College is even older. There is no reason why the South African College should not reach equal heights.

HOW FAR HAS IT PROGRESSED?

At the Inaugural Meeting certain amendments were made and these are at present being incorporated in the draft Constitution. When this work is completed, the Constitution will be submitted to the Minister of Economic Affairs for approval of the formation of the College as a non-profit-making company. Once this has been obtained, the Constitution will be published and the lists of the College will be thrown open to those who wish to associate themselves as Founders.

The Founders hope that when the lists are again thrown open, more members of the profession will join, since their contributions and their support, as well as their erudition and their sincerity, are required for a project that will in time exert a profound influence on the medical history of this country.

The purpose of this article is not to appeal for more Founders or funds, but to indicate to the profession that the foundation of the College of Physicians and Surgeons of South Africa will open up a new era of medical practice in this country, and that it will improve existing practice in both competence and co-operation

ELECTION OF MEDICAL COMMITTEES OF HOSPITAL BOARDS (CAPE)

The triennial elections of medical committees will take place in March 1955.

Doctors who would be entitled to vote in these elections are reminded that, in order to secure this right, they are required to apply for registration in the manner and within the time prescribed by regulation. The relevant regulations (Provincial Notice No. 365 of 1951, as amended by No. 499 of 1953, Cape) are as follows:

1. The election of members of medical committees shall take place triennially in the month of March.

2. A medical committee shall consist of not more than twelve elected members as may be determined from time to time by the Administrator after consultation with the Central Hospitals Committee.

3. The Chairman of each hospital board shall be the Returning Officer for the purpose of the election of members of medical committees.

REGISTRATION OF VOTERS

4. Every registered medical practitioner who has been in active practice in the area normally served by a provincial hospital for at least two years and who has attended two or more patients in the hospital at any time within the twelve months preceding the election shall, subject to the provisions of Regulation No. 5, be eligible to vote in the election of the medical committee of that hospital.

5. Every medical practitioner, who is desirous of being registered as a voter, shall make application for registration on a prescribed form obtainable from the Medical Superintendent and countersigned by him.

6. The completed application forms for registration as a voter shall be submitted to the Returning Officer not later than the 31st December preceding the election.

7. The Returning Officer shall compile and post in a conspicuous position in the hospital premises, not later than the 10th January preceding the election, a list of the medical practitioners entitled to vote.

8. In the event of any dispute arising in regard to the registration of voters, an appeal may be lodged, not later than the 24th January preceding the election, with the Director of Hospital Services whose decision shall be final.

NOMINATION AND ELECTION

9. The Returning Officer shall call for nominations for appointment to the medical committee and such nominations shall be submitted to him not later than the 15th February preceding the election, on a prescribed form obtainable from the Medical Superintendent of the hospital concerned.

10. The Returning Officer shall post a list of the persons nominated for appointment to the medical committee in a prominent position in the hospital premises for a period of not less than fourteen days prior to the date of the election.

11. The office of the Medical Superintendent of the hospital concerned shall, for the purposes of the election of members of the medical committee, be the polling station.

12. The election of members of the medical committee shall be by secret ballot and the completed ballot papers shall be placed in a sealed box in the office of the Medical Superintendent on a day in March and during the hours prescribed by the Returning Officer.

13. Immediately upon the close of the poll, or as soon thereafter as all voters then in the polling station have deposited their papers in the ballot box, the Returning Officer shall cover over the opening in, and seal up the ballot box so as to prevent the introduction of additional ballot papers.

14. The Returning Officer shall, as soon as practicable after the poll, count in the presence of not less than two witnesses the votes received and shall publicly announce the result of the election and, at the same time, declare the name or names of the person or persons elected. In the event of the number of votes being found to be equal for any two or more candidates, he shall by lot determine which shall be elected. All papers in connection with the election shall be retained by the Returning Officer for a period of ninety days after the poll and shall thereafter be destroyed by him, whereafter no disputes will be entertained.

CASUAL VACANCIES

15. When a member of a medical committee—

(*a*) dies; or

(*b*) resigns his office in writing to the Chairman of the committee; or

(*c*) is absent, without leave granted by the committee, from three consecutive meetings of such committee;

his office shall be declared vacant by the Chairman of the Committee, and such vacancy shall be filled until the next normal election by a person elected by a majority vote of the remaining members of the committee.

15*bis*. Whenever, in his opinion, it is necessary to hold an election of members of a medical committee at any time other than the time specified in Regulation *one*, the Director of Hospital Services shall direct that such election be held at a time specified by him, in which event the dates mentioned in these regulations for the doing of various acts will also not be applicable. Instead thereof, such dates as the Director of Hospital Services may specify, shall apply.

PASSING EVENTS : IN DIE VERBYGAAN

World Health Organization. At the plenary session of the 7th World Health Organization Assembly in Geneva in May 1954, the Union of South Africa was elected by secret ballot to be one of the 6 countries to designate a member to the Executive Board for the next 3 years. Six members of this 18-man executive committee retire every 3 years.

The Federation of Rhodesia and Nyasaland was admitted to Associate Membership of the World Health Organization by unanimous vote at the same meeting.

* * *

Union Department of Health Bulletin. Report for the 7 days ended 17 June 1954.

Plague, Smallpox: Nil.

Typhus Fever. Cape Province. The diagnosis of the Native case in the Ngqwara location in the Mqanduli district reported for the week ended 10 June, 1954, has now been confirmed by laboratory tests.

Epidemic Diseases in other Countries:

Plague: Nil.

Cholera in: Calcutta (India); Chittagong, Dacca, Chalna (Pakistan).

Smallpox in: Mogadiscio (Somalia); Bombay, Calcutta, Cochin, Delhi, Kanpur, Madras (India); Haiphong, Hanoi, Hué, Saigon-Cholon (Viet-nam).

Typhus Fever in: Baghdad (Iraq).

* * *

On 6 June a daughter was born to Dr. and Mrs. B. Tucker. Dr. Tucker is the District Surgeon, Kimberley.

On 3 June, a son was born to Mr. J. D. Visser, M.CH., Pretoria, and Mrs. Visser of Du Toitspan Rd., Kimberley.

Recently the M.O.H. of Kimberley, Dr. H. Wolfsohn, suffered a severe loss on the death of his father.

Dr. H. F. Loewenthal, F.R.C.S., Ed., 4 Park Road, Kimberley lost his mother after a sudden illness.

* * *

Mr. E. Colley, F.R.C.S. (Eng.), has changed his address to Martian House, Strand Street, Port Elizabeth.

* * *

Lede word daaraan herinner dat die Vereniging 'n ooreenkoms met die Atlas Versekeringsmaatskappy het waarvolgens hulle verseker-ing kan aangaan wat hulle dek teen eise deur derde partye of wat uit hul praktyke voortspruit.

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Navrae kan aan die kantoor van die Vereniging (Posbus 643, Kaapstad), of aan enige kantoor van die Atlas Versekeringsmaatskappy gerig word.

Mr. B. W. Franklin Bishop, F.R.C.S., who is working under Professor T. Pomfret Kilner, of the Nuffield Department of Plastic Surgery, the Churchill Hospital, Oxford, has been elected an Associated Member of the British Association of Plastic Surgeons. Mr. Franklin Bishop recently attended the Annual Clinical Meeting of the above Association held at the Royal College of Surgeons and the Great Ormond Street Hospital for Sick Children, London.

NEW PREPARATIONS AND APPLIANCES : NUWE PREPARATE EN TOESTELLE

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BRIEWERUBRIEK : CORRESPONDENCE

MITRAL VALVOTOMY IN PREGNANCY

To the Editor: Could Drs. Crawshaw *et alia* please explain in simple, clear language the exact meaning of the obscure paragraph in their paper which deals with the termination of early pregnancy? If they mean that mitral valvotomy without termination of the pregnancy is the correct treatment, why not say so? Whether the pregnancy be the first or not is quite irrelevant. Each pregnancy has to be assessed individually in the light of many variable factors.

The authors also state that 'we know that mitral valvotomy in pregnancy carries so little risk.' For the advocacy of their case—admirable as the results are, their patients only number 12—figures given by Morgan Jones are quoted. From these they deduce that 'those deaths most certainly due to the association of pregnancy with heart disease represent 2·8% of the series' (437 cases) and point out that acute pulmonary oedema was the most important cardiac cause of death during pregnancy. Pulmonary oedema is stressed again in the last paragraph of their article as a potential danger threatening every pregnant patient who has mitral stenosis.

Now in contrast to this article, an editorial article in the British Medical Journal of 15 May 1954, carries a sober note of warning: 'The operative mortality of 6% and 10% incidence of embolism at operation, should discourage operation in symptomless patients or in those with minimal disability.' These figures are most significant, particularly when compared with those deduced by the authors themselves from Morgan Jones' results.

That mitral valvotomy is an advance in treatment of the first magnitude and that in certain instances it is dramatically life-saving, goes without saying, but it is evident that there is much uncertainty as to its role in the management of the 'elective' case, pregnant or otherwise.

M. Segal

Southern Life Building,
3rd. Street,
Springs, Transvaal.

A PARADUODENAL FOSSA HERNIA

To the Editor: In the course of his report of an internal hernia of the jejunum, Dr. Gunn[1] comments that pregnancy influences the development of such a hernia. Now the only mechanism by which pregnancy can help to cause herniae is by an increase in intra-abdominal pressure, which occasions greater strain on weak parts of the abdominal walls.

It is in the highest degree unlikely that such an increase in pressure would affect unequally the various parts of the peritoneal cavity, of which the paraduodenal fossa is one. Several authorities[2,3] have pointed out this fact and have suggested a more satisfying aetiology for such herniae, namely errors of development during elongation and rotation of the gut and fusion of certain peritoneal layers.

I believe that the patient described in Dr. Gunn's report had lived with her hernia for the whole of her 33 years of life. The hernia was uncomplicated (i.e. unobstructed) and could hardly, therefore, have been a source of discomfort. Could Dr. Gunn tell us whether the patient thought that the operation performed on her provided relief?

E. N. Keen

Department of Anatomy,
University of Cape Town
21 June, 1954.

1. Gunn, K.V.O. (1954): S. Afr. Med. J., **28,** 515.
2. Andrews E. (1923): Surg. Gyne. Obstet., **37,** 740.
3. Longacre J. J. (1934): Surg. Gyne. Obstet., **59,** 165.

BREAST FEEDING

To the Editor: I wish to comment on one of the criticisms made by your reviewer of the book *Synopsis of Pediatrics* by John Zahorsky and T. S. Zahorsky in the *Journal* of 22 May 1954. Your reviewer says 'Statements like "the failure of breast-feeding is a calamity" . . . . are obviously behind the times'.

One cannot criticise too strongly such observations on breast-feeding as made by your reviewer, especially when most public health authorities dealing with maternal and infant welfare are doing all they can to stimulate more breast-feeding.

The advantages of breast-feeding, especially to the lower-income groups, cannot be too strongly stated and stimulated, and a statement such as that made in this book review is only likely to increase the calamity of the failure of breast-feeding.

I. Kessel

7 Aldswold Road,
Saxonwold,
Johannesburg.
2 June 1954.

COLLEGE OF PHYSICIANS AND SURGEONS OF SOUTH AFRICA

To the Editor: The Steering Committee of the College of Physicians and Surgeons has found itself unable to hit upon a solution of the problem of the Afrikaans translation of the degrees of the College and the name of the College. We would like to ask you, through your column, to ventilate this problem so that any correspondent who has ideas on the subject might be able to help us.

We are still undecided whether the initials of the Afrikaans and English should remain the same or whether separate initials for the Afrikaans version would be necessary.

I should be most grateful if you would publish this letter. Any practitioner who has a suggestion to make should write to me in order that I may place it before the Steering Committee.

T. B. McMurray
Hon. Secretary, Steering Committee
College of Physicians and Surgeons of South Africa

Union House,
Queen Victoria Street,
Cape Town.
18 June, 1954.

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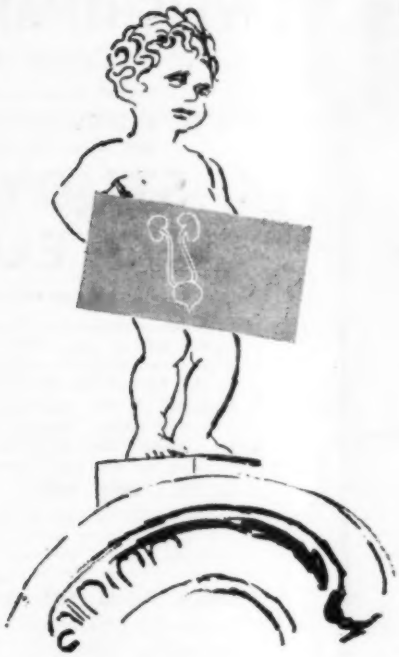

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Trafton, H. M., and Lind, H. E.: *J. UROL.* 69:315 (FEB.) 1953

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STUDY TOUR NO. 3

Commences in Hanover on August 16th, arriving in Berne August 29th. Visiting Bielefeld, Bochum, Cologne, Frankfurt (M), Heidelberg, Rothenburg o.T., Nuremberg, Munich, Innsbruck and Zurich.

STUDY TOUR NO. 4

Commences in Hamburg on September, 11th, arriving in Madrid September 25th. Visiting Frankfurt (M), Heidelberg, Bamberg, Erlangen, Munich, Ehrwald-leermoos Wangen/ Allgäu, Waldshut, Zurich and Geneve.

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JOHANNESBURG

Mediese Huis, Esselenstraat, 5. Telefone 44-9134/5, 44-0817
Medical House, 5 Esselen Street. Telephones 44-9134/5, 44-0817

ASSISTENTE/PLAASVERVANGERS VERLANG
ASSISTANTS/LOCUMS REQUIRED

(600) Aangename Natalse dorp. Assistent met oog op vennootskap.
(598) Transvaal. Plaasvervanger om so spoedig moontlik te begin, vir onbepaalde tyd. Salaris £3 3s. 0d. per dag, alles vry en £10 p.m. kartoelae.
(597) Johannesburg. Assistant required, to start immediately. Definite view to Partnership. Will suit young Jewish doctor.
(596) Reef Hospital town. An Assistant, preferably Jewish, to start as soon as possible. Own car necessary.
(595) Southern Rhodesia. Locum as from 21 September till 7 February. Own car necessary.
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(1457) Goed gevestigde Westelike Provinsie praktyk. Netto inkomste oorskry £3,000 per jaar. Huis beskikbaar. Verband kan gereël word. Volle besonderhede op aanvraag.
(1530) Karoodorp. Eenmanspraktyk sonder opposisie. Gemiddelde inkomste £2,000 p.j. Premie verlang £700. Huis te huur teen £8 p.m. D.S. aanstelling.
(1655) Cape Town. 2 Branch practices. Income 1953 £2,244. 2 Surgery and 3 waiting rooms available on very satisfactory terms. Definite scope for expansion. Nearest offer. Terms acceptable.
(1653) Noord-Kaapland. Vooruitstrewende woldistrik. Gemiddelde ontvangste per jaar £4,150. D.S. aanstelling. Koopprys £2,000 sluit ook al die geneesmiddels in, ter waarde van bykans £1,000. Huis te koop.
(1657) Oostelike Provinsie. Aangename plattelandse hospitaaldorp. Maandelikse inkomste ongeveer £180 p.m. Huis en spreekkamers beskikbaar teen billike huurgeld. Prys £750 of naaste aanbod. Sluit goeie voorraad geneesmiddels in. Terme in afbetaling kan gereël word. Goeie geleentheid vir beginner.
(1659) Windhoek, S.W.A. Well established prescribing practice for health reasons. Particulars on application.

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PRACTICE FOR SALE

(PD25) Durban. House and practice available, suitable for a surgeon. Details on application.
(PD26) Transkei. Practice established 8 months ago. Average monthly turnover £126/£140. Two appointments held District Surgeon and M.O. to Native Recruiting Corporation. New out-station clinics could be opened. Trout and river fishing within 15 miles. Will consider any offer.
(PD/27) Drakensberg Native Reserve area. Dispensing practice established February 1954 on part-time basis. Cash takings approximately £400. Buyer to take over drugs at cost, approximately £150 and equipment £60. Goodwill to be calculated as a percentage of the takings at the end of July.

LOCUMS REQUIRED

(LM8) Natal. Locum required from 16 June to 18 July. £2 12s. 6d. per day, all found. Country practice, practically no night work. Drakensberg area.
(LM9) Natal South Coast. Locum required for July. £3 3s. per day, all found. Must have own car. General mixed country practice.

ASSISTANTS REQUIRED

Assistant required, East Griqualand. Definite view to partnership. Old established partnership practice with one partner retiring. Full hospital facilities available. Must be bilingual and preferably with surgical experience. Commencing date 1 July 1954.
(AM2) Assistant required for trial period. If suitable, partnership will be offered. General practice in select area approximately 20 miles from Durban.

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Small woman doctor's practise in attractive coastal town Cape Province. Income £500-700. Suitable for part-time or semi-retirement, but with great possibilities. Consulting and waiting room at low rental. Premium £300 for quick sale. Apply A.V.O. P.O. Box 643, Cape Town.

Provincial Administration of the Cape of Good Hope

UNIVERSITY OF CAPE TOWN

JOINT MEDICAL STAFF FOR GROOTE SCHUUR AND OTHER TEACHING HOSPITALS

VACANCY

1. Applications are invited from registered Medical Practitioners for appointment to the following vacant post:

DEPARTMENT OF GYNAECOLOGY AND OBSTETRICS

1 Post of Medical Practitioner, Grade A, with salary on the scale £500–600–660–720 per annum.

2. Conditions of service are prescribed in terms of Hospital Board Service Ordinance No. 19 of 1941, as amended, and the regulations framed thereunder.

3. In addition to the scale of salary indicated a cost-of-living allowance at rates prescribed from time to time by the Administrator is payable to whole-time officials and employees. The present rate is £352 per annum for married persons and £110 per annum for single persons.

4. The Joint Medical Staff is required to serve jointly the Provincial Administration of the Cape of Good Hope and the University of Cape Town.

5. Candidates must have up to and including three years' experience after graduation or two years' experience after registration.

6. The successful candidate if not already in the Hospital Board Service will be required to submit satisfactory birth and health certificates.

7. Application should be made on the prescribed form Staff 23, which is obtainable from the Director of Hospital Services, P.O. Box 2060, Cape Town, or from the Medical Superintendent of any Provincial Hospital or Secretary of any School Board in the Cape Province.

8. The completed application forms should be addressed to the Medical Superintendent, Groote Schuur Hospital, Observatory and must reach him not later than 24 July, 1954.

9. Candidates must state the earliest date on which they can assume duty.

M127197

Mine Medical Officer—Required

A vacancy exists for Resident Medical Officer of Health at Kamativi Tin Mines near Dett, Southern Rhodesia.

The Mine is nearing initial production and the numbers of staff involved at this stage are 40 European families and 400–500 natives, which will probably increase. A Clinic, with emergency operating theatre etc., is nearing completion and will be fully equipped.

Emoluments offered are as follows:

Basic Salary, inclusive C.O.L.A.	—	by arrangement—not less than £1000 per annum.
Pension Fund Contribution by Company.	—	5% of above.

Accommodation: A free modern house with Doctor's room for European patients, which is near by the Clinic and has just been completed.

Free electricity and water.

Transport: A Landrover pickup is provided.

Other: The Mine runs a Welfare Store and Butchery at which all normal domestic requirements can be purchased at reasonable prices.

If married and the wife is qualified, special consideration would be given to her appointment as Sister in Charge of the Clinic, if desired.

Private practice in Dett and in the neighbourhood may be carried on, subject to arrangements being approved by the Company.

Date required to begin duties—1 SEPTEMBER, 1954.

Applications should include full details of qualifications, previous experience, marital state, etc., and should be addressed Kamativi Tin Mines Limited, 8th Floor, Bradlows Buildings, Bulawayo.

Provinsiale Administrasie van die Kaap die Goeie Hoop

UNIVERSITEIT VAN KAAPSTAD

GESAMENTLIKE MEDIESE PERSONEEL VIR GROOTE SCHUUR- EN ANDER OPLEIDINGS-HOSPITALE

VAKATURE

1. Aansoeke word ingewag van geregistreerde Geneeshere vir aanstelling tot die volgende vakante pos:

DEPARTEMENT VAN GINEKOLOGIE EN VERLOSKUNDE

1 pos van Geneesheer, Graad A, met salaris volgens die skaal £500–600–660–720 per jaar.

2. Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens No. 19 van 1941, soos gewysig, en die regulasies wat daarkragtens opgestel is.

3. Benewens die salarisskaal soos aangedui is 'n lewenskostetoelae betaalbaar aan voltydse beamptes en werknemers teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word. Die teenswoordige tarief is £352 per jaar vir getroude en £110 per jaar vir enkel persone.

4. Van die Gesamentlike Mediese Personeel word vereis om die Provinsiale Administrasie van die Kaap die Goeie Hoop en die Universiteit van Kaapstad gesamentlik te dien.

5. Kandidate moet tot en met inbegrip van drie jaar ondervinding na ontvangs van Graad of twee jaar ondervinding na registrasie hê.

6. Die geslaagde kandidaat, indien, nie reeds in die Hospitaalraadsdiens nie, moet bevredigende geboorte- en gesondheidsertifikate indien.

7. Aansoek moet gedoen word op voorgeskrewe vorm (Staf 23), wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of Sekretaris van enige Skoolraad in die Kaapprovinsie.

8. Die ingevulde aansoekvorms moet aan die Mediese Superintendent, Groote Schuur Hospitaal, Observatory, gerig word, en moet hom nie later as 24 Julie 1954 bereik nie.

9. Kandidate moet die vroegste datum meld waarop hulle diens kan aanvaar.

M127197

Tsumeb Corporation, Limited

Senior medical officer and assistant medical officer required by Tsumeb Corporation, Limited, for their Mine Hospital at basic salaries of £95 and £85 per month respectively, plus current c.o.l.a., at present approximately £25 per month for married officers and £20 for single officers. Duties involve care of employees and their families and mine accident cases. Private practice permissable. Fees may be charged for confinements and operations on members of employees' families. Annual leave consists of 21 days after year of service and thereafter 28 days plus £40 leave bonus in all cases. Unfurnished house available at nominal rental for married employees and furnished quarters for single employees. Assistant Medical Officer required to assume duties 1 September 1954 and Junior Medical Officer as soon as possible. Successful applicants would be permitted to apply for post of District Surgeon. Apply, giving particulars of previous appointments and experience to: Tsumeb Corporation, Limited, Tsumeb, South West Africa.

Anglo American Corp. of S.A., Ltd.

RELIEVING MEDICAL OFFICER

A medical officer with about 2-3 years' general experience is required by the Corporation for relieving duties on its various mines in South Africa and Rhodesia. A house will be available at a nominal rental should the successful applicant be married.

Applications, stating full personal particulars and giving details of education, qualifications and experience, should be addressed to: The Personnel Officer, P.O. Box 4587, Johannesburg.

Provincial Administration of the Cape of Good Hope

HOSPITALS DEPARTMENT

HOSPITAL BOARD SERVICES: VACANCIES

1. Applications are invited from Registered Medical Practitioners for appointment to the following vacant posts:

Institution	*Post*	*Emoluments*	*Closing date*	*Applications must be addressed to*
Livingstone Hospital, Port Elizabeth	Medical Practitioner, Grade B	£720x40—960 p.a.	27.7.54	The Medical Superintendent, Livingstone Hospital, Port Elizabeth.
do.	Medical Practitioner, Grade A (3 posts)	£500-600-660–720 p.a.	27.7.54	do.

2. The conditions of service are prescribed in terms of Hospital Board Service Ordinance No. 19 of 1941, as amended, and the regulations framed thereunder.

3. In addition to the scale of salary indicated a cost of living allowance at rates prescribed from time to time by the Administrator is payable to whole-time officials and employees. The present rate is £352 per annum for married persons and £110 per annum for single persons.

4. The successful candidates, if not already in the Hospital Board Service, will be required to submit satisfactory birth and health certificates.

5. Application must be made on the prescribed form (Staff 23) which is obtainable from the Director of Hospital Services, P.O. Box 2060, Cape Town, or from the Medical Superintendent, of any Provincial Hospital or Secretary of any School Board in the Cape Province.

6. Candidates must state the earliest date on which they can assume duty.

M127214

Provinsiale Administrasie van die Kaap die Goeie Hoop

HOSPITAALDEPARTEMENT

HOSPITAALRAADSDIENS: VAKATURES

1. Aansoeke word ingewag van Geregistreerde Geneeshere vir aanstelling tot die volgende vakante poste:

Inrigting	*Pos*	*Emolumente*	*Sluitings-datum*	*Aansoeke moet gerig word aan*
Livingstone-hospitaal, Port Elizabeth	Geneesheer, Graad B	£720x40—960 p.j.	27.7.54	Die Mediese Superintendent, Livingstone-hospitaal, Port Elizabeth.
do.	Geneesheer, Graad A (3 poste)	£500–600–660–720 p.j.	27.7.54	do.

2. Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens nr. 19 van 1941, soos gewysig, en die regulasies wat daarkragtens opgestel is.

3. Benewens die salarisskaal soos aangedui is 'n lewenskostetoelae betaalbaar aan voltydse beamptes en werknemers teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word. Die teenswoordige tarief is £352 per jaar vir getroude en £110 per jaar vir enkel persone.

4. Die geslaagde kandidate, indien nie reeds in die Hospitaalraadsdiens nie, moet bevredigende geboorte- en gesondheidsertifikate indien.

5. Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23) wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of by die Sekretaris van enige Skoolraad in die Kaapprovinsie.

6. Kandidate moet die vroegste datum meld waarop hulle diens kan aanvaar.

M127214

University of the Witwatersrand Johannesburg

ALEXANDRA HEALTH CENTRE AND UNIVERSITY CLINIC

AMENDED NOTICE

Applications are invited from suitably qualified medical practitioners for the post of part-time Medical Officer in the above-mentioned Institution. *Salary* £320 *per annum plus statutory cost-of-living allowance* (*at present* £158 12s. 0d. *per annum*). The hours of duty are 24 hours in each week arranged in accordance with the instructions of the Medical Superintendent.

Applications to be sent to the Assistant Registrar, Medical School, Hospital Hill, Johannesburg from whom further particulars may be obtained.

The closing date for applications is 31 *July*, 1954. 4497

(*amendments in italics*)

Rhodesia Railways

VACANCY FOR ADDITIONAL RAILWAY SURGICAL OFFICER: BULAWAYO

Applications are invited, from registered Medical Practitioners, for the post of additional Railway Surgical Officer, Bulawayo.

Salary. £1,000 per annum without any allowances except a Transport Allowance at the rate of £100 per annum: Private Practice permitted.

Leave. 40 days Vacation Leave per annum (accumulative).

Experience. Higher surgical qualification necessary.

Duties. Further information will be supplied to suitable applicants.

Applications accompanied by copies of recent testimonials, stating age, qualifications, previous experience, marital state, nationality, birthplace and name of two persons to whom reference can be made, should be forwarded to the Chief Medical Officer, Rhodesia Railways, P.O. Box 792, Bulawayo. M.D.1139

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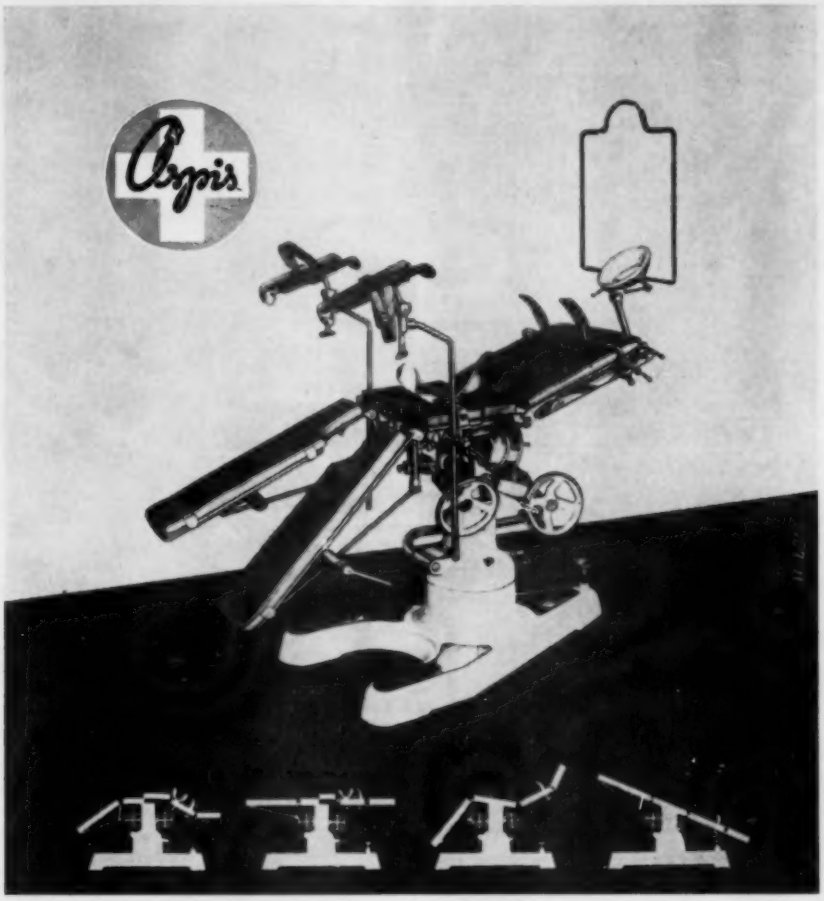

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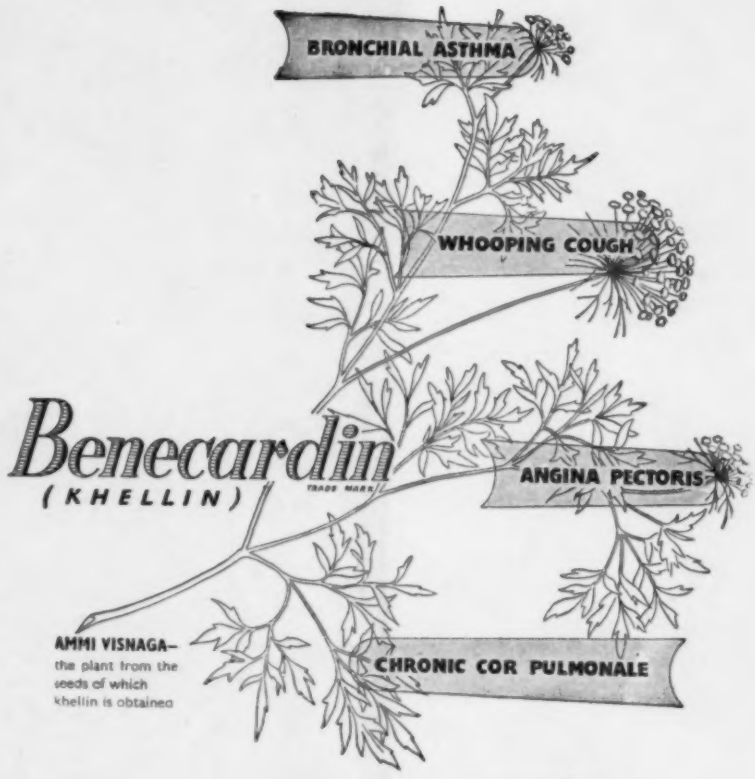

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